JOURNAL

of the

AMERICAN PODIATRY ASSOCIATION

ANNUAL MEETING
WASHINGTON, D. C.
AUGUST 22-26, 1958

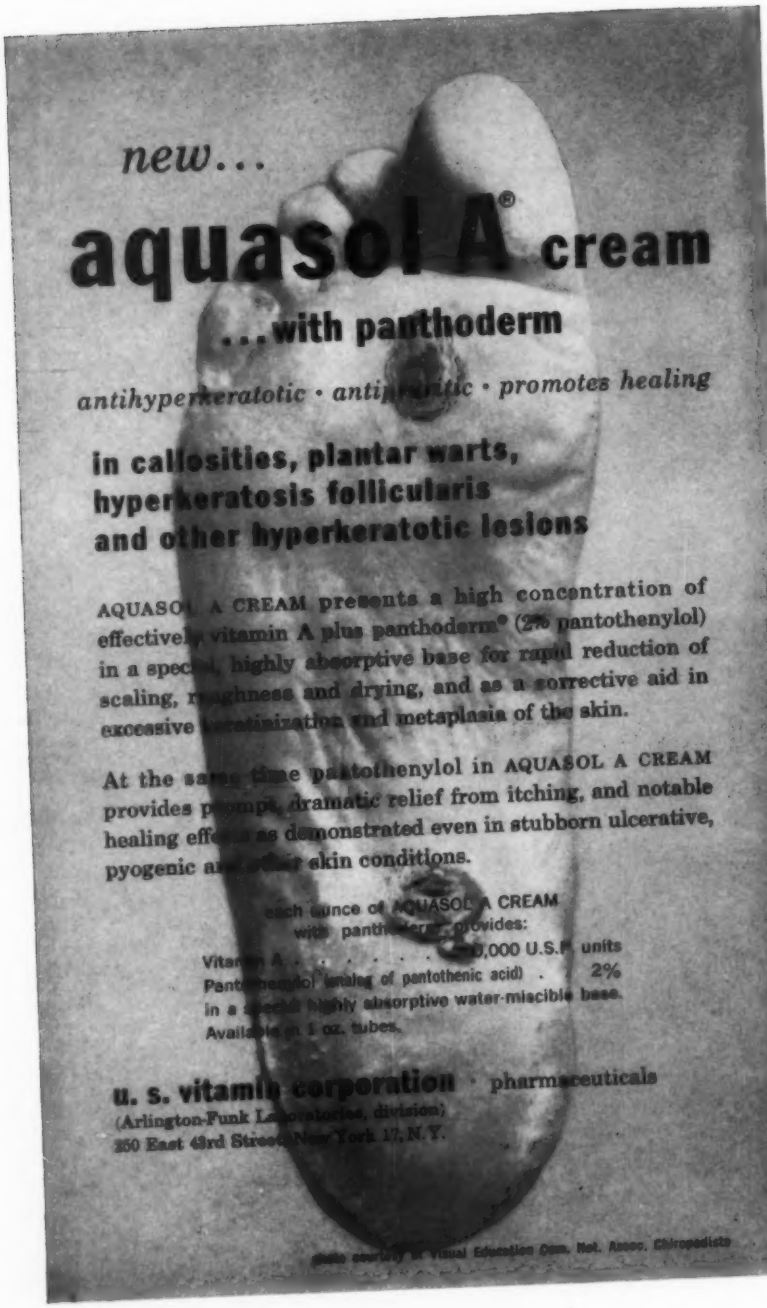
The Official Publication of the Podiatry-Chiropody Profession

FOOT SURGERY ISSUE

Table of Contents ——— Page A6

VOLUME 48, NUMBER 6

JUNE, 1958



new...

aquasol A® cream

...with panthoderm

antihyperkeratotic · antipruritic · promotes healing

in callosities, plantar warts, hyperkeratosis follicularis and other hyperkeratotic lesions

AQUASOL A CREAM presents a high concentration of effectively vitamin A plus panthoderm® (2% pantothenylol) in a special, highly absorptive base for rapid reduction of scaling, roughness and drying, and as a corrective aid in excessive keratinization and metaplasia of the skin.

At the same time pantothenylol in AQUASOL A CREAM provides prompt, dramatic relief from itching, and notable healing effects as demonstrated even in stubborn ulcerative, pyogenic and other skin conditions.

each ounce of AQUASOL A CREAM with panthoderm provides:

Vitamin A . . . . . 50,000 U.S.P. units

Pantothenylol (analog of pantothenic acid) . . 2%

in a special highly absorptive water-miscible base.

Available in 1 oz. tubes.

U. S. vitamin corporation · pharmaceuticals

(Arlington-Funk Laboratories, division)

250 East 43rd Street, New York 17, N.Y.

photo courtesy of Visual Education Com. Nat. Assoc. Chiropodists

NOW AVAILABLE FOR USE IN THE FOOT DOCTOR'S OFFICE

THE WEHLER TOE TERMINUS INDICATOR

The very inexpensive answer to a longfelt need of the professional foot specialist for a simple easy to use device that accurately indicates where the foot terminates within a shoe without the use of X-ray. It can be used for both feet of men, women, children.

First, you determine the toe length in stocking feet. (The instrument is useable for both right and left feet.)

Second, you put on the shoe and determine the toe length as described in the instructions which are supplied with each device.

THE WEHLER TOE TERMINUS INDICATOR is being applied as part of the accurate shoe fitting techniques practiced in Foot-So-Port Shoe Stores, where it has been discovered that 7 out of ten persons (including professional men) who come in for the first time have been previously wearing their shoes too short.

★

We are now able to make this device available to the doctor for use in his own office at a nominal cost. Address SALES RESEARCH AGENCY, MUSEBECK SHOE COMPANY, Oconomowoc, Wisconsin.

WHEN A "SPECIFIC FOUNDATION" SHOE IS INDICATED IN THE FOOT REHABILITATION OF YOUR PATIENT . . .

IN MANY CASES OF SHOE THERAPY THE FOLLOWING SPECIFIC CONSTRUCTION FEATURES ARE PRESCRIBED TO SUPPLY THE BASIC FOUNDATION AS A MECHANICAL ADJUNCT . . .

AS IN FOOT-SO-PORT SHOES FOR MEN—WOMEN—CHILDREN WITH . . .

STRONGEST STEEL SHANK

LEFT: *The Large Steel* Shank embedded in plastic wood which gives a non-collapsing support to the outer weight bearing arch. This is the area requiring the strongest support and the point at which shoes not so strongly constructed as Foot-So-Port have break-down failures and cannot hold up the wearer.

RIGHT: Foot-So-Port *Patented Heel Wedge* fills in and rounds out the inside of the shoe to give more support at this vital spot and forms a cupped heel seat.

MEDIAL LONGITUDINAL AND HEEL WEDGE

RIGHT: Foot-So-Port Shoe construction is only possible because *the lasts used* in making Foot-So-Port Shoes are *designed to do the best job possible in accommodating the human foot.* While it is true that no two feet are exactly the same, it is also true that all feet are curved, not flat, at many places.

CONTOURED LASTS

This regular line of Foot-So-Port Shoes for men, women and children is available through any of the Foot-So-Port Shoe Stores or Agencies in various cities throughout the United States. Please consult your classified telephone directory for listing of nearest one, or write to address below.

ASK TO SEE A CUT-AWAY SHOE VISUALIZING THE ABOVE FEATURES (AND MANY OTHERS) THROUGH ANY FOOT-SO-PORT SHOE STORE OR AGENCY—OR WRITE TO

FOOT-SO-PORT SHOE CO.—Div. of MUSEBECK SHOE CO.—
OCONOMOWOC—WISCONSIN

for office application ● *for patient's use at home*

DESITIN®
OINTMENT

an incomparable soothing, protective, lubricant, healing agent in numerous common podiatric conditions such as . . .

- **heloma and tyloma**
- **dermatitis**
- **inflamed nail grooves**
- **ulcers**
- **wounds**
- **sore joints**
- **scaling**
- **after nail removal**

DESITIN OINTMENT combines high grade Norwegian cod liver oil (with its unsaturated fatty acids and high potency vitamins A and D in proper ratio for maximum efficacy) zinc oxide, talcum, petrolatum and lanolin. Tubes of 1 oz., 2 oz., 4 oz., 1 lb. jars.

DESITIN POWDER, scientifically balanced medicinal powder, is saturated with high grade Norwegian cod liver oil, and therefore it will not deprive the skin of its natural fat.

samples and reprint on request

DESITIN CHEMICAL COMPANY
812 Branch Ave., Providence 4, R. I.

JOURNAL
OF THE
AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

3301 16th Street, N. W., Washington 10, D. C.
NOrth 7-4587

A. Rubin, D.S.C., Editor

National Advertising Representative
The Gordon M. Marshall Company
30 West Washington Street
Chicago 2, Illinois

EXECUTIVE COUNCIL

Dr. Jonas C. Morris, *President*
108 W. Merchant Street, Audubon, N. J.

Dr. George E. Guenzler, *President Elect*
302 Smith Building, Freeport, Ill.

Dr. Marvin W. Shapiro, *Vice President*
1059 Spitzer Building, Toledo, Ohio

Dr. Marvin D. Marr, *Vice President*
204 Paramount Building, Cedar Rapids, Iowa

Dr. Felton O. Gamble, *Retiring President*
1888 N. Country Club Road, Tucson, Ariz.

Dr. Morse K. Upshaw, Jr.
511-13 Lamar Life Bldg., Jackson, Miss.

Dr. Alec C. Levin
1835 Eye St., N.W., Washington, D. C.

Dr. Raymond K. Locke
134 Engle Street, Englewood, N. J.

Dr. Harry I. Horowitz
30-96 Steinway St., Astoria, L. I., N. Y.

Dr. Earl G. Kaplan
14608 Gratiot Ave., Detroit, Michigan

Dr. Charles R. Brantingham
311 Security Bldg., Long Beach, Calif.

A. Rubin, D.S.C., *Secretary*

All expressions of opinion and all other statements are published on the authority of the writer over whose signature they appear, and are not to be regarded as expressing the views of the American Podiatry Association, unless such statements or opinions have been adopted by the Association.

Deadline for *Journal* copy is the 10th of the month before publication (example: copy for June issue should be in our hands by May 10th.) The *Journal* is usually mailed between the 10th and 15th of the month noted on the issue (the June issue is mailed between the 10th and 15th of June).

Manuscripts must be typewritten, double spaced, and an original copy must be submitted. References should give name and initials of author, volume, page, month and year of publication in the case of periodicals, and publisher and place and year of publication in the case of books. Illustrations must be clear photographs. Glossy prints are preferred. Drawings must be made in black ink on heavy paper or cardboard. Any illustrations should bear the author's name and be numbered in the order in which they are referred to in the text. Illustrations must not be pasted on the manuscript. Legends should be placed on a separate sheet. Tables are not illustrations and should be numbered separately.

Articles are accepted with the understanding that they have not been published previously and that they are submitted solely to the *Journal*. Orders for reprints may be placed at the time manuscripts are submitted.

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative. Advertising and editorial copy must conform to the official standards established by the Association.

Subscription is included in the annual membership dues of the American Podiatry Association. The subscription rate for non-members is $10.00 a year in advance.. Single copies $1.00 each. Remittance should be made payable to the American Podiatry Association.

Notice of change of address should be received six weeks before the change is to become effective. Old and new address must be given.

The *Journal of the American Podiatry Association* is published monthly and copyrighted in 1958 by the American Podiatry Association.

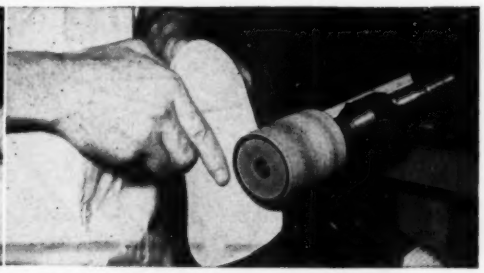
Entered as second class matter at the P. O. at Boston, Mass., March 27, 1934, under the act of March 3, 1879, re-entered March 3, 1958. Publication office, 375 Broadway, Boston, and Editorial Executive offices, 3301 16th St., N.W., Washington 10, D. C.

Breathe Easy Again with the

new Stryker PediVac

Eliminates All Dust As You Grind Toe Nails and Foot Appliances

Powerful suction, designed for fine dust removal, draws all dust away immediately.



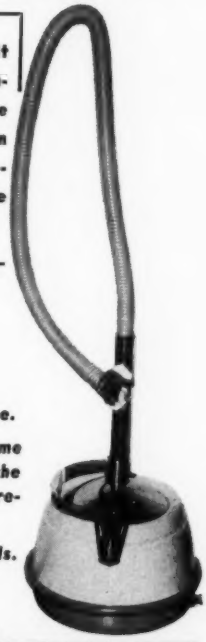
Messy dust, caused by grinding appliances requiring adjustment, is eliminated.

Yes, Breathe Easy Again

Every Chiropodist runs the well-known risk of serious lung infection through constant inhalation of fungus dust generated in grinding the toe nails —

- The PediVac Shield fastens quickly to the foot close to the toes without interfering with grinding procedure.
- The PediVac hose is internally supported to keep the hose off the floor.
- The PediVac occupies only 15 inches of office floor space.
- Rolls easily on casters.
- Dust is collected in a disposable bag at base of the PediVac.
- Plaster dust is readily picked up from plaster casts removed with the Stryker Cast Cutter.

This new unit created much interest at the Conclave in recent Chiropody Science Atlantic City.



Important Notice.

For a limited time you can have the PediVac at a reduced rate.

Write for details.

Stryker SURGICAL AND HOSPITAL EQUIPMENT

Orthopedic Frame Company

420 ALCOTT STREET • KALAMAZOO, MICHIGAN

Manufacturing Quality Medical Equipment for 15 Years

Distributed in Canada by: Fisher & Burpe, Ltd., Winnipeg

Exclusive Agent for Export: Schueler & Co., 75 Cliff St., N. Y.

TABLE OF CONTENTS

	Page No.
Transplantation of the Flexor Digitorum Brevis in Hammer Toe Surgery L. R. McCAIN, D.S.C., F.A.C.F.S.	233
Surgical Intervention for Calcaneal Spur HENRI L. DuVRIES, D.S.C., M.D.	235
Surgical Obliteration of Tendon Sheath Tumors Containing Rice Bodies MARVIN J. LURIE, B.S., Pod.D.	241
Heloma Surgery BERNARD LEVIN, D.S.C., A.C.F.S.	244
Preliminary Evaluation of Chiropodical Surgery HUGH CREDILLE, B.S., D.S.C.; W. M. FOO, B.S., M.H.A., D.S.C.; A. J. HARLER, D.S.C.; R. J. HOLMES, D.S.C.; RICHARD LaVEAU, D.S.C.; WM. REED, D.S.C.; JAMES WOOLSEY, D.S.C.	245
Clinical Uses of Promethazine in Podiatric Medicine and Surgery G. E. DACRE, D.S.C.	248
Os Intermetatarseum LORY WATERS, D.S.C.	252
Clinically Speaking	
Ainhum: A Case Report E. B. ROSS, B.A., D.S.C.	255
Foreign Bodies—A Case Report H. S. ESTERSOHN, D.S.C.	256
Subungual Exostosis: A Simplified Surgical Procedure R. KENNETH SANDEL, D.S.C., F.A.C.F.S.	257
A Prophylactic Surgical Procedure A. G. HELLER, JR., D.S.C.	258
Advance Registration for Annual Meeting	269
President Morris' Message	260
President of the United States of America	261
Our Newest Members of the Profession	262
Proposed Amendment to Constitution and Bylaws	262
Youth Fitness Committee	263
Washington Report	264
We Have a Date in '58 RAYMOND K. LOCKE, D.S.C.	265
Tentative Scientific Program—1958 Annual Meeting	266
Golf Tournament	269
Report of Council on Education	270
Techniques in Foot Surgery	277
The Podopediatric Clinic	279
Pharmaceutical Preparations for the Profession	281
Podiatry-Chiropody Abstracts	283
Digests from the Literature	285
Organization News	A23
Legal and Legislative	A25
Women's Auxiliary	A26
Deaths Reported	A27
Communication from the Museum Committee	A27
Pennsylvania Membership Committee Report	A28
Communications from the Profession	A29
Foot Health Award	A36
Convention Dates and Meeting Notices	A37
Mood Elevators	A38
Advertisers Index	A40
Classified Ads	A41

Attending your Regional Meeting is a "MUST"

THE ANNUAL MEETING

OF THE

AMERICAN PODIATRY ASSOCIATION

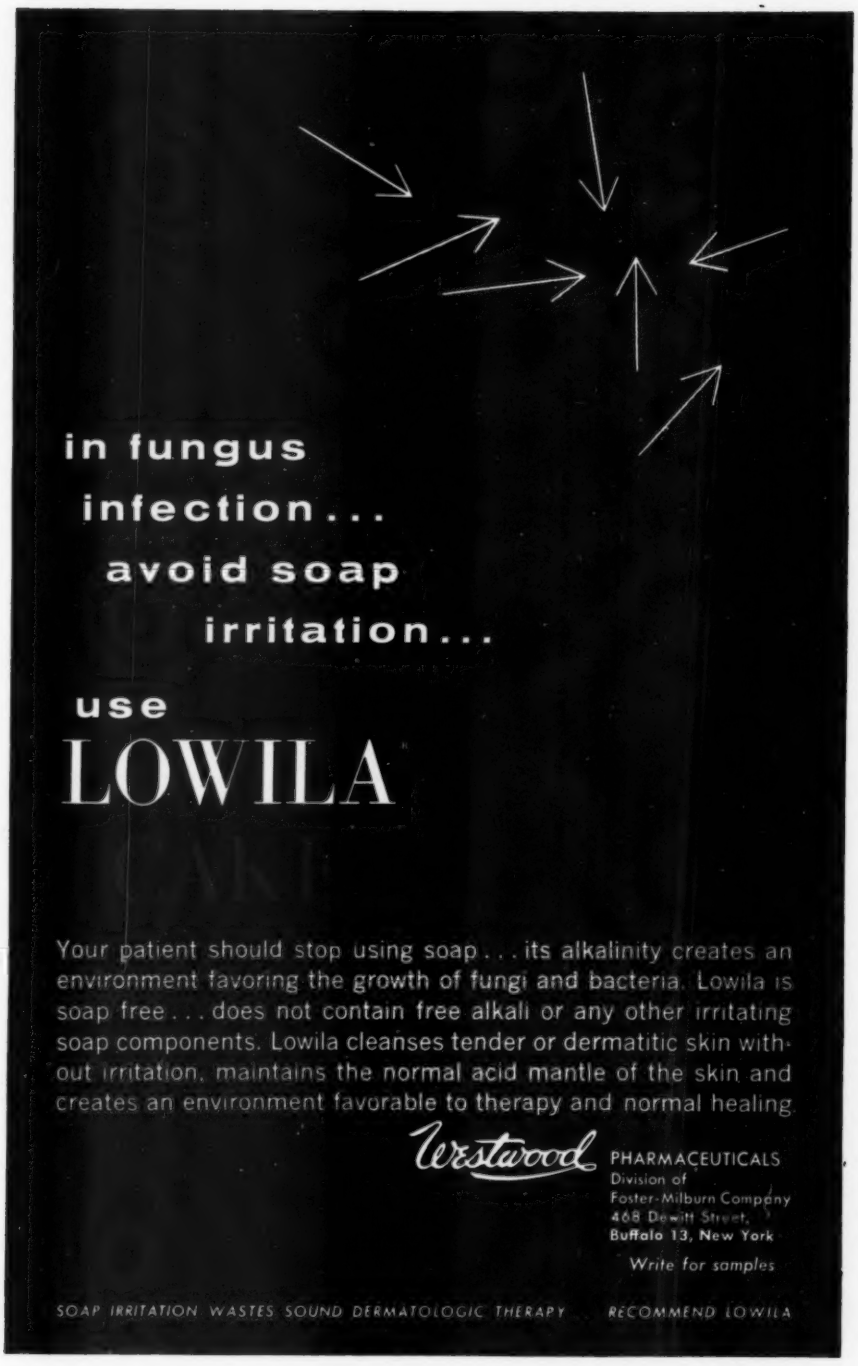
is another "Must"

THE NATION'S CAPITAL INVITES YOU
TO VISIT ITS WONDERS

OUTSTANDING PROGRAM SEE PAGES 265-269

FAMILY PLAN AT SHOREHAM HOTEL

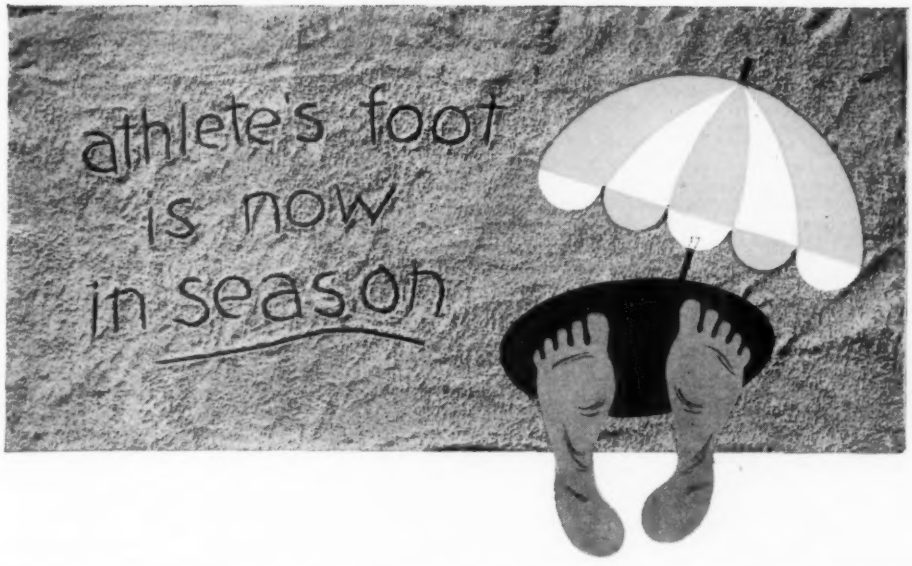
WASHINGTON, D. C. **AUGUST 22-26, 1958**


in fungus
infection...
avoid soap
irritation...
use
LOWILA
Your patient should stop using soap... its alkalinity creates an environment favoring the growth of fungi and bacteria. Lowila is soap free... does not contain free alkali or any other irritating soap components. Lowila cleanses tender or dermatitic skin without irritation, maintains the normal acid mantle of the skin and creates an environment favorable to therapy and normal healing.
Westwood
PHARMACEUTICALS
Division of
Foster-Milburn Company
468 Dewitt Street,
Buffalo 13, New York
Write for samples
SOAP IRRITATION WASTES SOUND DERMATOLOGIC THERAPY
RECOMMEND LOWILA

AFFILIATED STATE SOCIETIES

Showing Society, President and Secretary

Alabama Association of Chiropodists	Dr. W. T. Aucoin, Van Antwerp Bldg., Mobile, Ala. Dr. Elizabeth P. Sealy, 34 S. Perry St., Montgomery, Ala.
Arizona Chiropody Association	Dr. Martin Snyder, 2629 E. Broadway, Tucson, Ariz. Dr. Irwin D. Shapiro, 2814 N. 7th Ave., Phoenix, Ariz.
Arkansas Association of Chiropodists	Dr. A. M. Dyer, 900 W. Fourth St., Little Rock, Ark. Dr. Walter C. Gigerich, Arkansas Nat'l Bank Bldg., Hot Springs, Ark.
California Association of Chiropodists, Inc.	Dr. Robert Jacoby, 2161 Allston Way, Berkeley, Calif. Dr. Robert O. Johns, 209 Post St., San Francisco, Calif.
Colorado Association of Chiropodists	Dr. Carl Ritz, 1554 California St., Denver, Colo. Mrs. L. I. Lorett (Ex. Sec.), 4871 S. Penn, Englewood, Colo.
Connecticut Chiropody Society Inc.	Dr. Michael Tortora, 46 Milbank Ave., Greenwich, Conn. Dr. Margaret L. Halloran, 75 Pratt St., Hartford, Conn.
Delaware, Chiropody Society of	Dr. Harold W. Orr, 2210 Baynard Blvd., Wilmington, Del. Dr. Edward K. Schlanger, 1318 Washington St., Wilmington, Del.
District of Columbia Podiatry Society	Dr. William H. Weslar, 1801 K St., N. W., Washington 6, D. C. Dr. Bernard Laps, 1150 Connecticut Ave., N.W., Washington 6, D. C.
Florida, Chiropody Association of	Dr. Allan S. Horn, 414-16 Empire Bldg., St. Petersburg, Fla. Dr. Joy E. Adams, 401 Fla. Natl. Bank Bldg., St. Petersburg, Fla.
Georgia Podiatry Association	Dr. C. J. Pompei, Persons Bldg., Macon, Ga. Dr. Ernest Godwin, 1101 Williams St., Valdosta, Ga.
Idaho Association of Chiropodists	Dr. M. D. Harris, 341 West Clark, Pocatello, Idaho Dr. E. J. Yacks, 17 Powell Bldg., Coeur d'Alene, Idaho
Illinois Chiropody Society	Dr. Jack Stern, 25 E. Washington St., Chicago, Ill. Dr. Max L. Golde, 2125 Broadway, Rockford, Ill.
Indiana State Podiatrists Association	Dr. R. R. Kannally, 342 Illinois Bldg., Indianapolis, Ind. Dr. H. C. Winckelbach, 523 Merchants Bank Bldg., Indianapolis, Ind.
Iowa State Chiropody Association	Dr. C. B. Dunshee, 121½ First Ave., West, Oskaloosa, Iowa Dr. D. K. LeDuc, 408 City National Bank Bldg., Council Bluffs, Iowa
Kansas State Chiropody Association	Dr. C. R. Bittenbender, 819 Vermont St., Lawrence, Kansas Dr. Herbert R. Stone, 112 E. Chestnut, Garden City, Kansas
Kentucky Association of Chiropodists	Dr. L. D. Oppenheimer, Jr., 402 Coppin Bldg., Covington, Ky. Dr. Chester A. Nava, 728 Starks Bldg., Louisville, Ky.
Louisiana State Chiropodists' Association	Dr. Joseph Weinberg, 5300 Freret St., New Orleans, La. Dr. Harry Wax, 1018 Maison Blanch Bldg., New Orleans, La.
Maine, Chiropody Society of	Dr. John Madigan, 602-A Congress St., Portland, Maine Dr. Gerald M. Rosen, 152 Main St., Biddeford, Maine
Maryland Chiropody Association	Dr. Charles Stein, 5122 Park Heights Ave., Baltimore, Md. Dr. Michael Sherman, 121 W. Saratoga Ave., Baltimore, Md.
Massachusetts Chiropody Association	Dr. Sidney M. Heller, 244 Main St., Milford, Mass. Dr. Sidney G. Holmes, 206 Huntington Ave., Boston, Mass.
Michigan Chiropody Association	Dr. J. E. Snyder, 234 W. Michigan Ave., East Lansing, Mich. Mr. Dwight Jarrell, 164 Hickory Ridge Rd. South, Milford, Mich.
Minnesota Association of Chiropodists	Dr. M. G. LaPierre, 320 Marquette Bank Bldg., Minneapolis, Minn. Dr. Ernest S. Ueland, 7700 Lyndale Ave. South, Minneapolis, Minn.
Mississippi Society of Chiropodists, Inc.	Dr. C. R. Johnson, 1 Leyser Building, Greenville, Miss. Dr. M. K. Upshaw, Jr., 511-13 Lamar Life Bldg., Jackson, Miss.
Missouri Association of Chiropodists	Dr. Florence M. Peters, 906 Sharp Bldg., Kansas City, Mo. Dr. C. B. Footlick, 520-22 12th & Walnut Bldg., Kansas City, Mo.
Montana Association of Chiropodists	Dr. Virgil Overcast, 204 Wilma Bldg., Missoula, Montana Dr. L. M. Jennings, 411 First National Bank Bldg., Bozeman, Mont.
Nebraska Association of Chiropodists	Dr. Norman F. Svoboda, 239 W. 6th, Fremont, Nebr. Dr. L. G. Lefler, 239 W. 6th, Fremont, Nebr.
Nevada Association of Chiropodists	Dr. Wilbur W. Sylvester, 321 S. 5th St., Las Vegas, Nev. Dr. William A. Edwards, 150 No. Arlington Ave., Reno, Nevada
New Hampshire Podiatry Association	Dr. Harvey V. Harrison, 440 Central Ave., Dover, N. H. Dr. T. M. Levingston, 39 Pleasant St., Portsmouth, N. H.
New Jersey Chiropodists' Society	Dr. Clarence Bookbinder, 321 High St., Burlington, N. J. Dr. Jack Horwitz, 463 High St., Burlington, N. J.
New Mexico Podiatry Society	Dr. Paul J. Stevens, 1833 San Mateo Blvd., N.E., Albuquerque, N. M. Dr. Charles W. Boesenberg, 922 Tijeras, N.W., Albuquerque, N. M.
New York, The Podiatry Society of the State of	Dr. Theodore B. Eden, 158 East Union St., Bayshore, N. Y. Mr. G. Hollander (Ex. Sec.), 353 W. 57th St., New York, N. Y.
North Carolina Chiropodists' Association	Dr. Carlos T. Cooper, Jr., 210 O'Hanlon Bldg., Winston-Salem, N. C. Dr. D. J. Cameron, 504 Murchison Bldg., Wilmington, N. C.
North Dakota Association of Chiropodists	Dr. T. W. Cockrell, 5 Kemper Block, Minot, No. Dak. Dr. E. B. Snuff, 611 1st Ave, No., Fargo, No. Dak.



Susceptibility factors play an important part in the occurrence and spread of athlete's foot. With the advent of warm weather, individuals who have had the disease are prone to exhibit recurrences or reinfection. Frequently, this can be prevented by the continuous prophylactic use of Desenex preparations.

Desenex®
OINTMENT — POWDER
SOLUTION

fast relief from itching

prompt antimycotic action

continuing prophylaxis

NIGHT and DAY treatment

AT NIGHT — Desenex Ointment (zincundecate) 1 oz. tubes. —

DURING THE DAY — Desenex Powder (zincundecate) — 1½ oz. container.

ALSO — Desenex Solution (undecylenic acid) — 2 fl. oz. bottles.

In otomycosis — Desenex Solution or Ointment.

Write for samples.

Maltbie

MALTBIE LABORATORIES DIVISION • WALLACE & TIERNAN, INC. • Belleville 9, N. J.

PD-75

Ohio Chiropodists Association	Dr. N. C. Bianco, 1516 First National Tower, Akron, Ohio Mr. J. E. Farmer (Ex. Sec.), Fifty W. Broad St., Columbus, Ohio
Oklahoma Chiropody Association	Dr. Donald R. Landrum, 1432 S. Peoria Ave., Tulsa, Okla. Dr. H. R. Johnson, 401 N. Beard St., Shawnee, Okla.
Oregon State Association of Chiropodists	Dr. W. R. Schiess, 209 E. Third St., The Dalles, Oregon Dr. George McCauley, 1700 N. E. 41st St., Portland, Oregon
Pennsylvania, Chiropody Society of	Dr. T. P. Huels, 19 S. Mercer St., Greenville, Pa. Dr. Arnold W. Newman, 5411 Chester Ave., Philadelphia, Pa.
Rhode Island Podiatry Society	Dr. Frank Goldstein, 290 Westminster St., Providence, R. I. Dr. Samuel Kouffman, 677 Hope St., Providence, R. I.
South Carolina Podiatry Association	Dr. James D. Hill, 125½ W. Whitner St., Anderson, S. C. Dr. H. A. McAninch, 117 Schuyler Bldg., Spartanburg, So. Car.
South Dakota Association of Chiropodists	Dr. Edward Laga, 303 Medical Arts Bldg., Watertown, S. Dak. Dr. Margaret Avery, 311 Western Union Bldg., Aberdeen, S. Dak.
Tennessee Chiropody Association	Dr. William J. Thomas, 1318 Poplar Ave., Memphis, Tenn. Dr. Ronald E. Fields, 224 Bennie Dillon Bldg., Nashville, Tenn.
Texas, Chiropody Society of	Dr. Douglas Guthrie, Jr., 112 No. 25th St., Waco, Texas Dr. Robert K. Bunch, 904 Hermann Professional Bldg., Houston, Tex.
Utah State Association of Chiropodists	Dr. Clyde Smith, 210 Eccles Bldg., Ogden, Utah Dr. Lorin Richards, 826 9th East, Salt Lake City, Utah
Vermont Chiropody Association	Dr. H. V. Hight, 6 Second St., Newport, Vt. Dr. Regis P. Nolin, 14 Clarke St., Burlington, Vt.
Virginia, Podiatry Society of	Dr. Samuel Kaufman, Chief Tassle Bldg., Martinsville, Va. Dr. Herman Chapel, 644 New Monroe Bldg., Norfolk, Va.
Washington State Chiropody Association	Dr. Lloyd W. Salter, 339 Wells St., Renton, Wash. Dr. Kurt Blau, 909 Broadway, Tacoma, Wash.
West Virginia, Chiropody Society of	Dr. Robert R. Maury, Hawley Bldg., Wheeling, W. Va. Dr. G. M. Arnold, 216½ Seventh Ave., So. Charleston, W. Va.
Wisconsin Society of Chiropodists	Dr. L. B. Thompson, 705 Kenosha Natl. Bank Bldg., Kenosha, Wisc. Dr. Eugene V. Hurtienne, 316 Security Bank Bldg., Sheboygan, Wisc.
Wyoming Podiatry Society	Dr. John B. Holthouse, 119 S. 7th St., Worland, Wyoming Dr. Duane NeuSchultz, 2201 West A, Torrington, Wyoming

Affiliated Organizations

N.A.C. Women's Auxiliary—Mrs. Lon Cooper, 346-352 Ohio Bldg., Sidney, Ohio
Military Association of Chiropodists—Lt. John L. Charlton, Jr., D.S.C., Chiropody Clinic, Walter Reed Army Hospital, Washington, D. C.
American College of Foot Surgeons—Dr. J. M. Kohl, 3959 No. Lincoln Ave., Chicago, Ill.
American Society of Chiropodical Roentgenology—Dr. D. C. Rasmussen, City National Bank Bldg., Danbury, Conn.
Chiropody Bibliographical Research Society—Dr. S. E. Reed, 425 Kresge Bldg., Des Moines, Iowa
American College of Foot Orthopedists—Dr. Herman R. Siegler, 39 Flamingo Rd., Levittown, L. I., N. Y.
American Association of Hospital Chiropodists—Dr. Charles R. Brantingham, 311 Security Bldg., Long Beach, Calif.
American Podiatry Students Association—D. S. Weidner, 1420 Old Wyoming Rd., Reading, Pa.

Related

Federation of Chiropody Boards—Dr. L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.
American Association of Colleges of Chiropody—Dr. Charles E. Krausz, 926 W. Lehigh Ave., Philadelphia, Pa.
National Board of Chiropody Examiners—Dr. M. Marcus, 1898 Coral Way, Miami, Fla.
American Academy of Chiropodists—Dr. Jesse E. Titus, 10616 Euclid Ave., Cleveland, Ohio
American Podiatry Council—Dr. H. B. Bodian, 30 East 60th St., New York, N. Y.
Fellows Pedic Research Society—Dr Irving M. Sward, 4948 W. Dempster Rd., Skokie, Ill.
American Foot Health Foundation—Dr. Sidney Hirschberg, 107-07 Continental Ave., Forest Hills, N. Y.

ACCREDITED COLLEGES

California College of Chiropody
1770 Eddy Street
San Francisco, Calif.

Chicago College of Chiropody
1422 W. Monroe Street
Chicago, Ill.

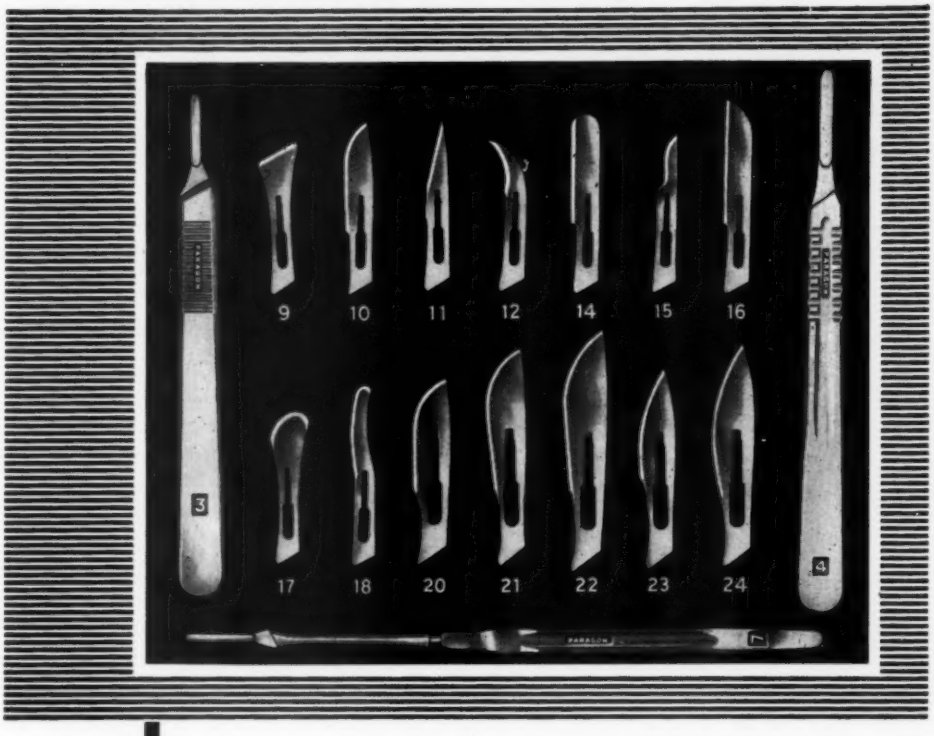
Illinois College of Chiropody and Foot Surgery
1327 North Clark Street
Chicago, Ill.

New York College of Podiatry
53 East 124th Street
New York, N. Y.

Ohio College of Chiropody
2057 Cornell Road
Cleveland, Ohio

Temple University, School of Chiropody
1810 Spring Garden Street
Philadelphia, Pa.

PARAGON BLADES: Time Saving... Always Sharp



ENJOY the convenience of having new, sharp blades always ready to use.

Versatile Paragon Blades add as much as thirty minutes of productive time to your day because they require no sharpening. You use each blade until it begins to lose its edge, then discard it.

Paragon Blades are fashioned from the finest English Sheffield steel. They are advertised exclusively to the chiropody profession.

Keep a large supply of Paragon blades on hand. Order today from your chiropody supply house, or direct.

PARAGON BLADES

Exclusive American Distributor:

PARAGON SURGICAL
4700 EDGEWOOD AVENUE
OAKLAND 2, CALIFORNIA

STATE BOARD MEETINGS FOR EXAMINATION AND LICENSURE

Alabama
The Alabama Medical Board of Examiners. **Board Secretary:** Dr. Elizabeth P. Sealy, 34 South Perry Street, Montgomery, Ala.

Arizona
The Arizona State Board of Chiropody Examiners. **Board Secretary:** Dr. Julius Citron, 40 E. Thomas Rd., Phoenix, Arizona.

Arkansas
Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 800 First National Bank Bldg., Fort Smith, Ark.

California
The next meeting of the California Board of Medical Examiners Chiropody Examining Committee will be held June 17-18, 1958, San Francisco, Calif. **Board Chairman:** Dr. Abraham Hoffman, 2320 Sutter St., San Francisco, Calif. **Executive Secretary:** Mr. Wallace Thompson, Rm. 530, 1020 N St., Sacramento, Calif.

Colorado
Colorado State Board of Chiropody Examiners. **Board President:** Dr. G. F. Helbig, 327 Logan St., Denver, Colo.

Connecticut
The Connecticut Board of Examiners in Chiropody will meet for reciprocity and examination on July 8-9, 1958 at the State Capitol, Hartford, Conn. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, Conn.

Delaware
The State Board of Chiropody Examiners of Delaware. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dela.

District of Columbia
The Board of Podiatry Examiners of the District of Columbia will meet for examination July 15-16, 1958. **Board Secretary:** Dr. Harry L. Hoffman, 1740 Massachusetts Ave., N.W., Washington 6, D. C.

Florida
The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

Georgia
The next board meeting of the Georgia State Board of Podiatry Examiners will be held for examination on June 16-17, 1958 at the State Capitol Bldg., Atlanta, Ga. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Idaho
The Idaho State Board of Chiropody-Podiatry will meet for reciprocity and examination on July 8-10, 1958, at the Capitol Bldg., Boise, Idaho. **Board Secretary:** Dr. J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

Illinois
The Illinois Chiropody Examining Committee will meet for reciprocity and examination on June 17-19, 1958 at the Department of Registration, 160 No. La Salle St., Chicago, Ill. **Superintendent of Registration:** Frederic B. Selcke, Dept. of Registration and Education, Room 112, State House, Springfield, Ill.

Iowa
The Iowa State Chiropody Board of Examiners will meet for examinations on June 9-11, 1958, at the Capitol Bldg., Des Moines, Iowa. **Board Secretary:** Dr. C. C. Reinheimer, 214½ First Ave. West, Newton, Iowa.

Kansas
The next board meeting of the Kansas State Board of Podiatry Examiners will be held for reciprocity and examination on June 13-14, 1958 at the Kansas University Medical Building, Kansas City, Kansas. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. J. Nash, M.D., 864 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky
The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 728 Starks Bldg., Louisville, Ky.

Maine
The Maine Board of Examiners in Chiropody and Podiatry will meet for reciprocity and examination on July 8-9, 1958 at State House, Augusta, Maine. **Board Secretary:** Adam P. Leighton, M.D., 142 High St., Portland, Me.

Maryland
The Maryland Board of Chiropody Examiners will meet for examination in July, 1958 at 11 E. Chase St., Baltimore, Md. **Board Secretary:** Dr. Maurice E. Walsh, 11 Dundalk Avenue, Baltimore 22, Md.

Massachusetts
The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at the State House, Boston, Mass. **Board Secretary:** Dr. Charles H. Thorner, 910 Furnace Brook Parkway, Quincy, Mass.

Minnesota
The Minnesota Board of Chiropody Examiners will meet for examination on June 19-20, 1958 at the Minnesota State Capitol, St. Paul, Minn. **Board Secretary:** H. W. Leibold, D.S.C., 221 Hamm Bldg., St. Paul 2, Minn.

Mississippi
The Mississippi State Board of Health, **Board Secretary:** Dr. Felix J. Underwood, Old Capitol, Jackson, Miss.

Missouri
The next board meeting of the Missouri State Board of Chiropody will be held for reciprocity and examination in the Jefferson Bldg., Jefferson City, Mo., on June 14-15, 1958, **Board Secretary:** Dr. L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.

Montana
The next board meeting of the Montana Chiropody-Medical Board of Examiners will be held when the need arises for reciprocity or examination at the State Capitol, Helena, Mont. **Board Secretary:** Thomas L. Hawkins, M.D., Helena, Montana.

Nebraska
The next board meeting of the Nebraska State Board of Examiners in Chiropody will be held at the State Capitol Bldg., Lincoln, Nebr. in July 1958. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

Nevada
The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, Nevada.

New Hampshire
The New Hampshire Board of Registration in Chiropody. **Board Secretary:** M. Atkinson, M.D., 61 S. Spring St., Concord, N. H.

New Mexico
The next board meeting of the New Mexico State Board of Chiropody will be held for reciprocity and examination on July 12-13, 1958 at Albuquerque, N. Mex. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N. E., Albuquerque, N. M.

New York
The New York State Board of Podiatry Examiners. **Board Secretary:** Mr. James O. Hoyle, 23 S. Pearl St., Albany, New York.

North Carolina
The North Carolina State Board of Chiropody Examiners. **Board Secretary** Dr. Charles Darby, P. O. Box 55, Statesville, N. C.

New! SIMPLIFIED TECHNIQUE ALLOWS MOLDING IN YOUR OWN OFFICE

CUSTOM-MOLD TRADE MARK SHOES and SANDALS

Men's

Women's

Women's. Also men's and women's style with wedge heel

- **Designed to meet the shoe therapy needs of the modern Podiatrist and Chiropodist.**
- **Special lasts and patterns permit the shoe to be constructed over a removable cork inlay, full length of foot.**
- **In this inlay a special molding compound is spread which takes the mold of the foot, including a well formed crest, ample natural room for toes, and a body weight balance to restore natural movement.**
- **Molding technique is quick, clean and foolproof. Molded cork inlays are easily modified for adjustments.**
- **Unbranded. No label or trade mark. Sold only by the profession.**

Custom-Mold Shoes and Sandals retain their maximum eye appeal. Made in orthopedic shoe shop by trained custom shoe makers. Genuine Welt construction. Choice leather. Uppers stitched completely around sole and heel. An orthopedic shoe made for a purpose that will satisfy your patients.

There are no messy casts or time-consuming delays in returning casts to the factory. You handle everything. You have complete control, thus assuring the quickest delivery and best possible fitting shoes for your patients.

A Completely New Concept in Modern Shoe Construction . . . Performance Proved

The scientific functional design of Custom-Mold Shoes, augmented by an inlay that can easily be changed, plus the exclusive molding technique has been proved in actual practice by Podiatrists and Chiropodists, and you build in every correction needed.

Any foot imbalance or deformity requiring corrective measures can be formed in the mold, thus eliminating painful pressure points. Custom-Mold Shoes give the quickest, most complete and lasting relief to sufferers of a variety of foot ailments, including ordinary foot fatigue.

No Waiting • Fast Delivery From Large IN STOCK Size Range

FILL IN AND MAIL TODAY

CHIROPODY SUPPLY HEADQUARTERS, INC.
1425 N. Clark St., Chicago 10, Ill.
111 Fifth Avenue, New York 3, N. Y.
3223 East 46th St., Los Angeles 58, Calif.

Please send me Custom-Mold Shoe and Sandal catalog and confidential price list.

Dr._____

Address_____

_____

City_____ Zone____ State_____

North Dakota
The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call in 1958 at 303 Black Bldg., Fargo, N. Dak. **Board Secretary:** Dr. E. B. Snuff, 303 Black Bldg., Fargo, No. Dak.

Oklahoma
The Oklahoma State Board of Chiropody will meet for examination Sept. 20, 21, 1958, at 1217 No. Walker St., Oklahoma City, Okla. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Oregon
Oregon State Chiropodists Examining Board. **Board Secretary:** Harold M. Erickson, M.D., 914 State Office Bldg., Portland 1, Oregon.

Pennsylvania
Pennsylvania State Board of Chiropody Examiners will meet for examination on July 23-24, 1958, in Harrisburg, Pa. **Board Chairman:** Dr. Ralph H. Orr, 424 Colorado Drive, Erie, Pa. **Board Secretary:** Dr. Jack S. Pincus, 26 N. Third St., Harrisburg, Pa.

Rhode Island
The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

South Carolina
The South Carolina Board of Chiropody Examiners. **Board Secretary:** Dr. Charles W. Clark, 535 Harden St. Five Points, Columbia, South Carolina.

South Dakota
The next board meeting of the South Dakota State Board of Chiropody Examiners will be held for reciprocity and examination in Sioux Falls, S. D. in June, 1958. **Board Secretary:** Dr. Fred D. Rule, 204 Kresge Bldg., Sioux Falls, S. D.

Tennessee
The Tennessee Board of Registration in Chiropody. **Board Secretary:** Dr. Arthur Richert, 3355 Poplar St., Memphis, Tenn.

Texas
The Texas State Board of Chiropody Examiners will meet July 17-20, 1958 at the Hilton Hotel, Fort Worth, Texas. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Texas.

Utah
The Utah State Board of Chiropody Examiners. **Board Secretary:** Dr. A. Bowden, First Security Bank Bldg., Provo, Utah.

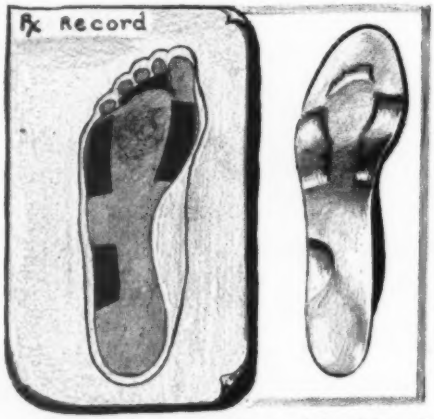
Vermont
Vermont Chiropody Association. **Board Secretary:** Dr. Regis P. Nolin, 14 Clarke St., Burlington, Vt.

Washington
The Washington State Board of Chiropody. **Board Secretary:** Edw. C. Dohm, Gen. Adm. Bldg., Olympia, Wash.

West Virginia
Medical Licensing Board of West Virginia will meet for examination on July 14-15, 1958 at 1800 E. Washington St., Charleston, W. Va. **Board Secretary:** N. H. Dyer, M.D., 1500 E. Washington St., Charleston, W. Va.

Wisconsin
The Wisconsin Board of Examiners. **Board Secretary:** Dr. O. J. Trimborn, 208 E. Wisconsin Ave., Milwaukee 2, Wis.

Wyoming
The Wyoming State Board of Registration in Chiropody-Podiatry will meet for examination in June, 1958 at the Capitol Bldg., Cheyenne, Wyo. **Board Secretary:** Dr. J. W. Scott, 21 East Works St., Sheridan, Wyo.



Rx—Weight bearing chart and Special Insole Balancer #50A created for chart

FUNCTIONAL DESIGN

OUR NEW
#50 SERIES

"THE SPECIAL INSOLE BALANCER"

Designed **to be Extra Thin—Flexible—Functionally Correct.**

Created **to fit into all types of shoes including Step-in Pumps—Dress Oxfords, and Casuals.**

Write Today for Literature

ARCHCRAFT LABORATORIES
Creators of Custom Foot Appliances
1807 ARCH STREET, PHILA. 3, PA.

PREPARATIONS FOR THE CHIROPODIST

Soapless Sudsing ***Antibacterial Detergent***

pHisoHex®

Cumulative bacteriostatic action in

Infections
(prophylactic-therapeutic)

Bromidrosis

Vascular disease of the extremities

pHisoderm® *(OILY TYPE)*

for dry feet and legs

Dependable Antiseptic for Office Use

ZEPHIRAN® CHLORIDE

(brand of benzalkonium chloride—refined)

Powerful
Economical
Versatile

Pioneer Local Anesthetic

NOVOCAIN®

(brand of procaine hydrochloride)

Quick onset
Dependable action
Excellent tolerance

WINTHROP LABORATORIES New York 18, N. Y., Windsor, Ont.

Write for informative illustrated booklet

DIRECTORY OF COUNCILS AND COMMITTEES

First Administrative Division—Dr. George E. Guenzler, *President Elect*

Council on Education

Dr. Stewart E. Reed, Chairman, 425 Kresge Bldg., Des Moines, Iowa

Council on Scientific Sections

Dr. Raymond K. Locke, Chairman, 134 Engle St., Englewood, N. J.

Dr. Milton Henenfeld, Coordinator, 450 Seventh Ave., N. Y., N. Y.

Committees:

Research—Dr. William F. Eads, Chairman, 1651 Garnet St., San Diego, Calif.

Scientific Exhibits—Dr. LeRoy C. Numbers, Chairman, 1327 N. Clark St., Chicago, Ill.

Dr. Edward Ganny, Co-Chairman, 1907 Eye St., N.W., Washington, D. C.

Foot Surgery—Dr. Lester A. Walsh, Chairman, 709 N. Colorado Ave., Midland, Texas

Roentgenology—Dr James E. Bates, Chairman, 5916 Greene St., Philadelphia, Pa.

Foot Orthopedics—Dr. Harvey Atkinson, Chairman, 462 Trapelo Rd., Belmont, Mass.

Hospital Practices—Dr. I. P. Forman, Chairman, 2250 N. Front St., Philadelphia, Pa.

Pharmaceutical—Dr. Ralph E. Owens, Chairman, 1700 Exchange Blvd., Oklahoma City, Okla.

Shoes—Dr. Edward C. Meldman, Chairman, 161 W. Wisconsin Ave., Milwaukee, Wis.

Children's Foot Health—Dr. John T. Sharp, Chairman, 1424 Old York Rd., Abington, Pa.

Council on Journalism

Dr. Alec C. Levin, Chairman, 1835 Eye St., N.W., Washington, D. C.

Committees:

Publications—Dr. Robert Shor, Chairman, 4480 Crenshaw Blvd., Los Angeles, Calif.

Nomenclature—Dr. Peter N. Varzos, Chairman, 25 E. Washington St., Chicago, Ill.

History and Library—Dr. Charles E. Krausz, Chairman, 810 Gilbert Rd., Cheltenham, Pa.

Council on Podiatry Therapeutics and Pharmacy

Dr. Harry L. Hoffman, Chairman, 1098 National Press Bldg., Washington, D. C.

Second Administrative Division—Dr. Marvin W. Shapiro, *Vice President*

Council on External Affairs

Dr. Felton O. Gamble, Chairman, 1888 N. Country Club Rd., Tucson, Ariz.

Committees:

Medical Relations—Dr. Irving Yale, Chairman, 44 E. Main St., Ansonia, Conn.

Nursing Relations—Dr. Victoria A. Auriene, Chairman, 221 Peoria Ave., Dixon, Ill.

Industrial Relations—Dr. John E. Green, Chairman, 108 Murray St., Binghamton, N. Y.

Commercial Relations—Dr. Edward H. Buchbinder, 10 Allyn St., Hartford, Conn.

Council on Foot Health Information

Dr. Earl G. Kaplan, Chairman, 14608 Gratiot Ave., Detroit, Mich.

Committees:

Public Education—Dr. H. L. Collins, Chairman, 318 E. State St., Columbus, Ohio

Public Relations—Dr. Burdette L. Anderson, 4379 West 219 St., Fairview Park, Ohio

National Health Program—Dr. Arnold W. Newman, Chairman, 5411 Chester Ave., Philadelphia, Pa.

Speakers Bureau—Dr. Charles W. Shuffle, Chairman, 1801 K St., N.W., Washington, D. C.

Audio-Visual—Dr. Marvin W. Shapiro, Chairman, 1059 Spitzer Bldg., Toledo, Ohio

Council on Legislation

Dr. Morse K. Upshaw, Jr., Chairman, 511-513 Lamar Life Bldg., Jackson, Miss.

Committees:

Federal Affairs—Dr. Charles Turchin, Chairman, 818 18th St., N.W., Washington, D. C.

State Affairs—Dr. Joy E. Adams, Chairman, 401 Florida National Bank Bldg., St. Petersburg, Fla.

Military Affairs—Dr. Joel H. Hill, Chairman, 119 E. Court Square, Decatur, Ga.

Third Administrative Division—Dr. Marvin D. Marr, *Vice President*

Council on Membership

Dr. Harry I. Horowitz, Chairman, 30-96 Steinway St., Astoria, L. I., N. Y.

Committees:

State Society Membership—Dr. Wm. S. King, Chairman, Three Sisters Bldg., Memphis, Tenn.

Vocational Guidance—Dr. L. B. Thompson, Chairman, 705 Kenosha National Bank Bldg., Kenosha, Wis.; Dr. Stanford S. Rudnick, *Co-Chairman*, 299 Main St., West Haven, Conn.

Students Organization—Dr. Edward L. Tarara, Chairman, Mayo Clinic, Rochester, Minn.

Ethics—Dr. Ronald E. Fields, Chairman, 224 Bennie Dillon Bldg., Nashville, Tenn.

Office Assistants—Dr. David M. Simon, Chairman, 2992 Bailey Ave., Buffalo, N. Y.

Council on Internal Affairs

Dr. Charles R. Brantingham, Chairman, 311 Security Bldg., Long Beach, Calif.

Committees:

Professional Economics—Dr. B. C. Egerter, Chairman, 507 Liberty Ave., Pittsburgh, Pa.

Museum—Dr. George Nelson, Chairman, 420 Kresge Bldg., Minneapolis, Minn.

Liaison to Affiliated Societies—Dr. Charles R. Brantingham, Chairman, 311 Security Bldg., Long Beach, Calif.

Constitution and By-Laws—Dr. Leo N. Liss, Chairman, 209 Post St., San Francisco, Calif.

National Youth Fitness Committee—*Co-Chairmen*, Dr. Seward P. Nyman, Farragut Medical Building, Washington, D. C., and Dr. Burdette L. Anderson, 4379 W. 219th St., Fairview Park, Ohio.

Committee on NAC Insurance—Dr. Irving Pashin, Chairman, 12 Catharine St., Poughkeepsie, N. Y.

IF A BANDAGE IS TOO MUCH B·F·I. may be just right!

Ideal first-aid dressing and surgical powder for minor abrasions; athlete's foot; tired, burning feet

B·F·I POWDER affords antibacterial protection—without caking or crust formation. The excellent clinging power of this finely subdivided powder provides effective covering against contact with air or friction with clothing.

B·F·I POWDER is astringent to the degree necessary to promote contraction of the skin and to reduce secretions.

The drying, absorbent action of B·F·I POWDER helps keep weeping areas dry, yet through the action of the bismuth compounds, allays irritation.

Use and recommend B·F·I POWDER for regular use by your patients. B·F·I promotes healing, absorbs and protects, but does not cake or irritate.

B·F·I is a trade-mark of Merck & Co., Inc.

MSD **MERCK SHARP & DOHME**
DIVISION OF MERCK & CO., Inc., PHILADELPHIA 1, PA.

This is Article No. 2 in a series of six devoted to foot problems common to children's feet.

Pronation In The Preschool And Ea

The term "pronation" is used to describe a weight-bearing attitude of the feet which consists of an outward roll of the heel bone and its attached tendoachillis, decreased height of the medial longitudinal arch, and abduction of the forefoot. Because this deformity is accompanied by a forward and medial displacement of the talus, there is usually a concomitant prominence of the talonavicular joint which is sometimes erroneously referred to as "ankle-bulge." It should be emphasized that this is a weight-bearing deformity, since practically all of the feet in this category at this age are found to present a normal arch contour in the absence of weight-bearing and gravitational stress.

Although pronation is unquestionably the most common postural foot problem in childhood, it should not be considered abnormal in the child of preschool age, unless certain other factors are coexistent. These include fatigue, pain in the foot or leg, awkward gait, nocturnal cramping, excessive breakdown of the medial shoe counter with abnormal heel and sole wear, and the presence on the foot of corns or calluses arising from the foot posture presented.

Continued on opposite page

A Reprint Of This Series Is Offered

A reprint of this article — and the other five in this continuing series — is available, without charge or obligation, at your request. The subjects individually covered are *Pronation in Pre-School and Early Childhood, Pronation in Adolescence, Pigeon Toe, Knockknees and Bow Legs, and Painful Heel.*

Yours For The Asking

A wedge chart, prepared for the professional man, illustrating corrective wedges and describing their work is yours for the asking.

A booklet on the care of the feet and advice on the selection of children's shoes will be sent to you in quantity at your request. This booklet — completely non-commercial — is suitable for presentation to young mothers in your practice.

Child Life
ARCH FEATURE SHOES

CHILD LIFE Arch Feature Shoes are readily adaptable to the wedging required for correcting the childhood deficiencies covered by this article. The basic arch feature shoe is illustrated here. It is adaptable for heel wedges from 1/16" to 1/4" according to size.

These advertisements first appeared

Early School Child

by A. Robin, D.S.C.* and John T. Sharp, D.S.C.†

It is a little recognized fact that the foot is not born to postural maturity. The feet of the infant and the early-walking child are immature antecedents of the adult foot. The bony framework of this young foot must be supplemented by the accrual of additional bone. Its ligaments must develop the great tensile strength required to maintain the arched structure of the foot against the superimposed influences of gravity and body weight. Its neuromuscular units must attain the strength and proper functioning of the reflexes, necessary for the forward propulsion of the body. And, as all these things are being accomplished, its highly complicated nervous system, correlating all parts into coordinated movement, must reach functional maturity so that the child can stand and walk upright in the presence of almost incredible gravitational resistance. For these reasons, pronation in the preschool child must be considered physiological, unless other symptoms are present.

It is now well known that certain bone anomalies are responsible for a percentage of cases of pathological pronation in childhood. These include the so-called Morton syndrome, variations in the construction of the talar head and the sustentaculum tali, calcaneonavicular bar, talocalcaneal bridge, and wedging of the navicular. Consequently, the scientific analysis of pronation in childhood must include a complete roentgenologic study.

A common factor predisposing to pronated foot is thc so-called "short heel cord," which is actually an abnormal shortening of the tendon of the triceps surae. Because of the construction of the ankle and subastragalar joints, shortening in this tendon forces the foot into a pronated posture in order to attain its full range of flexion on the leg. It follows, therefore, that pronated feet in children must be examined for this discrepancy.

The treatment of pronation in the preschool child, once it is established that therapeutic intervention is needed, is quite varied. The most commonly employed measures are: special shoes (with or without pads), wedging (see illustration), removable appliances such as the Whitman or Robert plate, and exercises. Exercises are given either alone or in conjunction with other corrective measures. Whatever the therapy employed, the basic pattern of therapy is continual maintenance of the foot in functional position. This may require the use of some device designed to control the foot during the sleeping hours. For this reason, the so-called "Dennis-Browne Splint" in recent vears has achieved some popularity.

Wedge may vary in thickness from 1/16" to 1/4" according to the age and weight of the child and severity of the deformity.

It should be remembered that the postural correction of pronation in the young child is a matter of years, not weeks. During this period of treatment, the patient must be examined at regular intervals, to insure that treatment is adequate.

In many instances periodic examination will suffice for treatment. In these cases use of placebos is sometimes necessary to allay parental anxieties.

REFERENCES

(1) Morton, D. J.: The Human Foot. New York, Columbia Univ. Press, 1942.

(2) Dickson, F. L. and Dively, R. L.: Functional Disorders of the Foot. Philadelphia, Lippincott Co., 1953.

**Secretary, National Association of Chiropodists, and Editor of its Journal. Formerly Director of the Foot Clinics, and Professor and Chief of Orthopedic Dept., Illinois College of Chiropody and Foot Surgery.*

†Professor of Chiropodal Pediatrics, Temple University, School of Chiropody.

HERBST Shoe Manufacturing Co., Milwaukee 45, Wisconsin

THE EASTERN UNDERWRITER

November 8, 1957

Average Family 90 Days Away From Financial Ruin

The National Thrift Committee recently stated that the average American family is only three months away from bankruptcy. They based their information on a recent survey conducted by leading insurance companies on the financial standing of middle class American families.

The survey pointed up the psychological and sociological toll taken by such perilous financial existence. Many families have little or no reserve to tide them over an emergency. . . . "How can they ever achieve peace of mind or family tranquility under situations like this?" they asked.

THE NEW

$10,000

MAJOR MEDICAL PLAN

for eligible members

of the

AMERICAN PODIATRY ASSOCIATION

provides an inexpensive solution for the burden of

CATASTROPHIC MEDICAL AND HOSPITAL BILLS

---

write for descriptive brochure

THE NAC AGENCY INC.
53 ACADEMY STREET
POUGHKEEPSIE, N. Y.

for the foot sore . . . try

TASHAN® CREAM *Roche*

In the practice of podiatry, TASHAN Cream belongs on the treatment table. TASHAN soothes, softens . . . stimulates healing in the following variety of foot conditions: ■ burning, itching feet ■ dry skin, after hydrotherapy ■ chronic eczema ■ dry, chafed feet ■ adhesive tape reactions ■ softening calluses, corns, "horny" heel ■ soothing after electrodesiccation ■ shoe "rub" ■ routine foot hygiene in diabetes ■ indolent ulcers.

TASHAN contains vitamins A, D, E, and *d*-panthenol in a non-sensitizing, absorptive cream base. In addition, TASHAN is compatible with most types of other indicated medications including boric acid powder, zinc oxide, ASTEROL® Ointment, neomycin and hydrocortisone. For your patients' feet —and for *your hands*, too—try TASHAN Cream. In 1-oz tubes and 1-lb jars. We will be pleased to send you a trial supply of TASHAN upon receipt of your request. Write to Professional Service Dept., Roche Laboratories.

ROCHE®

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc • Nutley • New Jersey

Experiments conducted under Army grant to Doctors from New York University Post Graduate Medical School and the University Hospital prove:

dry fungicidal powder helps prevent athletes foot

JOURNAL

OF THE

AMERICAN PODIATRY ASSOCIATION

THE OFFICIAL PUBLICATION OF THE PODIATRY-CHIROPODY PROFESSION

VOLUME 48 JUNE, 1958 NUMBER 6

TRANSPLANTATION OF THE FLEXOR DIGITORUM BREVIS IN HAMMER TOE SURGERY*

L. R. McCAIN, D.S.C., F.A.C.F.S.†
Chicago, Ill.

MANY operations and variations of these operations have been devised for the removal of helomas, or the straightening of hammer toes. The technique here described is not meant to replace other techniques, but is recommended in the proper situation.

Following surgery on hammer toes it is not uncommon to find that the shaft of the proximal phalanx tends to lie dorsally at an acute angle. Or if a capsulotomy has been done it may protrude laterally or medially, causing the patient discomfort. In a few instances, it has irritated the tissues to such an extent that a bursal formation developed between the shaft of the proximal phalanx and the tissue. In consultation with Abe Rubin, D.S.C.‡, it was decided that transplantation of the flexor digitorum brevis over the shaft of the proximal phalanx would help to hold the shaft down, and also keep it from deviating to either side.

Anatomy

The flexor digitorum brevis muscle lies in the middle of the sole of the foot immediately above the central portion of the plantar fascia, with which it is firmly united. It arises by a narrow tendon from the medial process of the tuberosity of the calcaneus, from the central part of the plantar fascia, and from the intermuscular septum between it and the abductor hallucis medially and the abductor digiti quinti laterally. It passes forward and

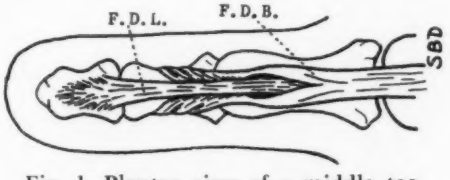


Fig. 1—Plantar view of a middle toe. Flexor Digitorum Brevis (F.D.B.) divides to form passage for Flexor Digitorum Longus (F.D.L.).

divides into four tendons, one for each of the four lesser toes. Opposite the bases of the first phalanges each tendon divides into two slips, to allow for the passage of the corresponding tendon of the flexor digitorum longus. The two portions of the tendon then unite and form a grooved channel for the reception of the accompanying long

*Presented at Annual Meeting, National Association of Chiropodists, Chicago, Ill., August 1957.
†Surgery Department, Illinois College of Chiropody.
‡Then Director of Foot Clinics, Illinois College of Chiropody.

flexor tendon. Finally, it divides a second time and is inserted into the sides of the second phalanx about its middle.

In each digit an osteofibrous canal is formed by the fibrous flexor sheath and the phalanges and plantar ligaments of the joints. Opposite the bodies of the proximal phalanges and second phalanges the fibrous bands are strong and the fibers are transparent; opposite the joints they are much thinner and the fibers are directed obliquely. Each canal contains a synovial sheath which is reflected on the contained tendons.

Two tendons enter the canal in each of the four smaller toes—a tendon of the flexor digitorum brevis and a tendon of the flexor digitorum longus. Opposite the posterior part of the first phalanx, the short flexor is superficial; but at the middle of the phalanx the tendon of the short flexor is perforated by the tendon of the long flexor, which passes forward to be inserted into the base of the terminal phalanx, while

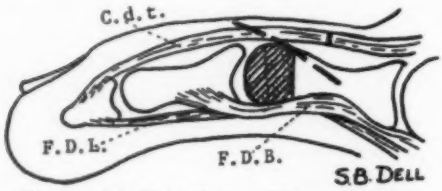


Fig. 2—Medial view. Heavy broken line indicates site of incision. Perpendicular line on conjoined dorsal tendon (C.d.t.) is point of division.

the tendon of the short flexor, beyond the perforation, splits into two parts which are attached to the margins of the second phalanx. Insofar as the kinesiology of the flexor digitorum brevis is concerned, it is a flexor of the first interphalangeal joints and the metatarso-phalangeal joints of the lesser toes.

Variations may be noted: The slip to the small toe is occasionally missing, or it may be replaced by a small fusiform muscle arising from the long flexor tendon or from the quadratus plantae.

Technique

With this anatomy in mind, we evolved the following surgical technique, which was first performed in April 1955:

A dorsomedial epithelial lineal incision was made extending from a point 1 cm. distal to and 1½ cm. proximal to the interphalangeal articular surface of the toe. The margins were retracted, and the proximal

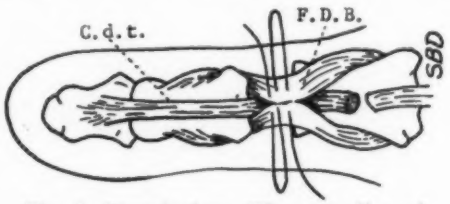


Fig. 3—Dorsal view. The two slips of the Flexor Digitorum Brevis (F.D.B.) are brought to dorsum and sutured to each other.

interphalangeal articulation identified. A dorsal transverse incision was made through the tendons of the extensor digitorum longus and brevis. Using further digital pressure on the distal aspect of the toe in a plantarward direction, the joint was disarticulated, exposing the flexor digitorum longus and brevis tendons. These were separated from the plantar ligament on the plantar aspect of the head of the proximal phalanx by sharp dissection. The head of the proximal phalanx was removed with bone rongeurs and the distal portion of the shaft was smoothed with a bone rasp. The two slips of the flexor digitorum brevis which are attached to the sides of the second phalanx were dissected free and held with an Allis forceps. The two slips were brought over the dorsal aspect of the shaft of the proximal phalanx, sutured together, and then sutured into the dorsal aspect of the shaft of the proximal phalanx with 000 chromic catgut sutures. No attempt was made to repair the resected dorsal tendon; however, the sides of the tendon sheath were approximated. The skin was closed, checked for good apposition, and sutured with 000 dermal sutures.

Two factors are involved in this procedure which should be mentioned. First, it should be remembered that the slips of the tendon of the flexor digitorum brevis lie superficial to the plantar interphalangeal ligaments and, consequently, more toward the plantar surface of the toe. It is necessary, therefore, to go below the plantar ligament before trying to pick up the tendons of the flexor digitorum brevis. This is easily done, but must be done without severing the plantar ligaments.

Second, the dermal sutures should remain in the wound for from three to five days longer than in conventional heloma surgery. This is necessary because there is slightly more trauma in this operation than in the usual hammer toe operations, and if this is done the wound does not tend to open, though it may look perfectly healed in the normal amount of time.

1791 W. Howard St.

SURGICAL INTERVENTION FOR CALCANEAL SPUR*

HENRI L. DUVRIES, D.S.C., M.D.
Chicago, Ill.

HEEL SPUR is an osteophytic outgrowth just anterior to the tuberosity of the calcaneus, extending along its entire width, or about 2 to 2.5 cm. The apex of the spur is embedded in the plantar fascia directly anterior to its origin. The spur may be symptomless, or it may be very painful, even disabling.

Calcaneal spurs are of three types:

1. Large spurs which are symptomless because the angle of growth is such that the spur does not become a weight-bearing point and any inflammatory changes have been arrested.

2. Large spurs which are painful upon weight-bearing because a depression of the longitudinal arch has altered the pitch of the calcaneus, so that the weight-bearing point causes intractable pain. (Figs. 12U and 13U).

3. Spurs with only a rudiment of proliferation and with an irregular, jagged outline, usually accompanied by an area of decreased density around the origin of the plantar fascia, indicating a subacute inflammatory process (Fig. 1). All calcaneal spurs doubtlessly begin in this way, but only a few become symptomatic at this stage since only in these few are the etiologic factors acute.

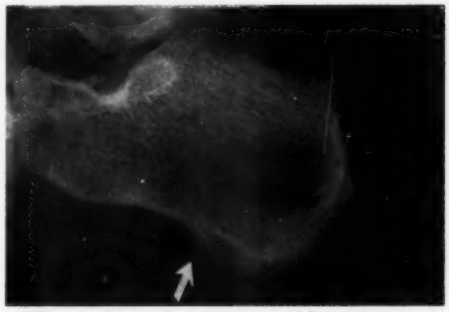


Fig. 1—Spur formation with subacute fibrositis.

Etiology

Heel spurs were long believed to be gonorrheal in origin. Blokhin (1937) noted that arteriosclerosis, gonorrhea, and syphilis played no part in the cause, but rather that heel spurs are a result of either functional overuse or an abnormality of the bones of the foot. Costa Bertani (1939) in a study of 18 cases found that heel spur was present in 40 per cent of

*Adapted, by permission, from Archives of Surgery 74: 536, 1957

patients with flatfoot. More recently Davis and Blair (1950) reported 15 cases of calcaneal spur in Strümpell-Marie disease. Heredity has been suggested as a factor. Gould (1942) reported exostosis of the heel in a father of six children; his third child, a son, had a spur. This son had four children, and his second child, a boy, had a heel spur. Gould suggested that the abnormality passed down the male line.

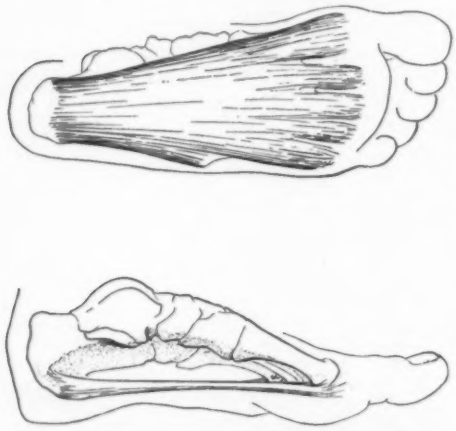


Fig. 2U—Note the relative width of the plantar fascia at its origin and insertion. L—The bowstring action of the fascia.

Twenty-five years ago I noted the discrepancy in the old gonorrheal theory. I found that the women with heel spur were often of foreign birth and mothers of large families—the type least apt to have been afflicted with a venereal disease. In my series of 37 cases there have been about an equal number of men and women, ranging in age from 37 to 61 years. The women were all of average height, but overweight, ranging from 170 to 315 pounds, the majority over 200 pounds. Seventy per cent of the men were stocky and overweight. Many of these patients had a serious pes planus and some eversion of the foot.

The most important casual factor in heel spur is mechanical rather than infectious, and the result of the following chain of events.

The plantar fascia, arising from the anterior lip of the tuberosity of the calcaneus which is about 2 cm. wide, fans out over the plantar surface of the foot and inserts into the fascial plane under the five metatarsal heads, measuring at its insertion about 10 cm. in width (Fig. 2). Since the plantar fascia functions as a bowstring for the entire plantar surface of the foot, any excess strain on the longitudinal arch exerts a maximum pull or strain at the acute angle of its origin. For this reason, "weak foot" and overweight which alter the pitch of the calcaneus, are important factors in producing excess strain. In time, a low-grade inflammatory process occurs in this area (the origin of the fascia), and causes secondary proliferation which ultimately forms a spur.

Diagnosis

Severe pain in the entire plantar surface of the heel, which is the principal symptom, aggravated by weight bearing, becomes progressively worse and even incapacitating. The entire plantar surface of the heel is tender upon palpation, with a point of maximal tenderness just anterior to the calcaneal tuberosity. Pinpointing

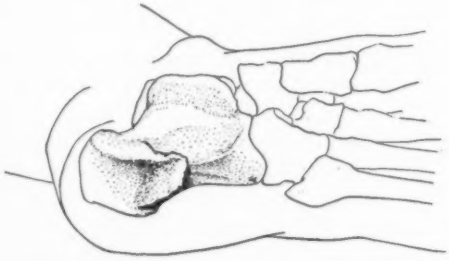


Fig. 3—The base of the spur extends across entire tuberosity.

this point of greatest tenderness on a radiogram will usually locate it immediately under the spur.

The pathologic change in the early stage is a fibrositis of low chronicity, with or

without pain anterior to the calcaneal tuberosity. Continuation of the process produces osteophytic changes and bone deposits in the sulcus just anterior to the tuberosity. The accumulation of new bone is self-limiting and the final spurs vary greatly in size and shape. Most commonly it has the shape of a triangular bar. Usually the medial lateral view on a radiogram is two dimensional and gives the

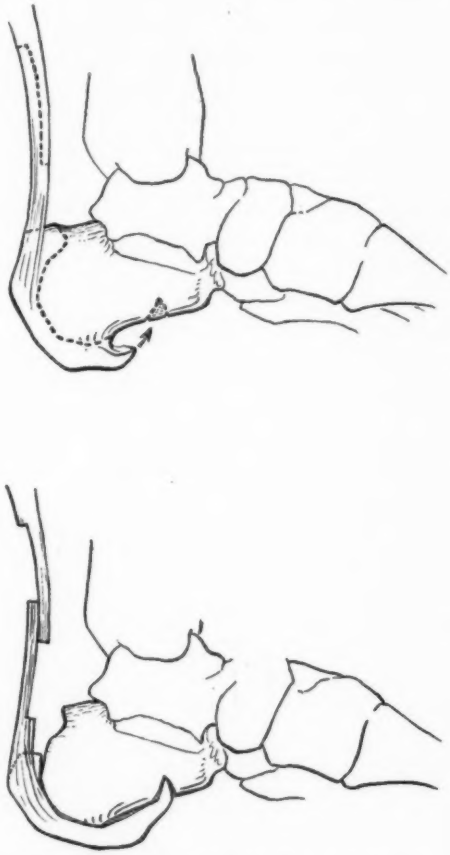


Fig. 4—Steindler's rotation osteotomy for calcaneal spurs.

impression that the spur is pointed like a tack, although actually it transcends the entire width of the tuberosity (Fig. 3).

Treatment

The asymptomatic case (Type 1) requires no attention. The fully formed symptomatic spurs usually respond to mechanical measures such as proper footgear,

Fig. 5—U-shaped flap approach for calcaneal exostectomy.

correction of static foot disability, increased rest of the foot, and an appliance which will have a transverse sulcus in its heel portion to accommodate the spur. In the intractable case (Type 2) surgical excision of the spur is indicated. For Type 3 (Fig. 1) medical and mechanical measures should be thoroughly exhausted before surgical intervention is considered, for at this stage of active fibrositis palliative measure may arrest the disease, whereas surgical intervention may only aggravate the condition.

Various operative procedures have been devised in treatment of heel spur. Steindler's rotation osteotomy (Fig. 4) of the calcaneus is designed to take all weight-bearing off the point of the spur by rotating the posterior portion of the calcaneus in such a manner that the spur is brought to lie in the horizontal plane and not in a vertical or oblique plane. This technique is as follows: A curved incision beginning on the lateral aspect of the foot, 1 in. above the insertion of the tendo Achillis, follows the tendo Achillis, then curves anteriorly and posteriorly and terminates at the lateral margin of the sole, anterior to the tuberosity of the calcaneus. The calcaneus is exposed and the periosteum stripped away, exposing the entire posterior and inferior portion of the calcaneus. A curved osteotomy through the

calcaneus is then performed, the line of osteotomy passing from a point anterior to the insertion of the tendo Achilles to a point just anterior to the insertion of the plantar fascia at the tuberosity. The plane of the osteotomy is at right angles to the lateral surface of the calcaneus.

Fig. 6—A linear incision, about 6 cm. long, is made on the medial side about 2 cm. above the medial plantar border of the skin.

A wedge is removed from the inferior surface of the anterior portion of the calcaneus, and the tendo Achillis is lengthened; then the posterior portion of the calcaneus, carrying the spur with it, is rotated anteriorly and superiorly into its new position. An ivory peg or steel pin is used to hold the posterior portion in place, thereby bringing the spur into the horizontal plane.

The procedure of Griffith and of Chang is commonly practiced. A U-shaped incision is made completely around the heel; the skin flap is reflected, exposing the plantar surface of the heel at the origin of the plantar fascia (Fig. 5). The fascia is severed at its origin and the spur amputated.

Blokhin used a modified Chang technique in 33 cases, which proved successful in the 17 patients followed up after one to four years. A U-shaped incision was made in the skin around the heel following the line where this skin changes to the thicker plantar skin. The flap of skin with its adherent layer of fat was lifted toward the sole in such manner as to expose the lower surface of the calcaneus. The bursa of the tendon calcaneus was then excised and the plantar fascia and muscles detached. The lower plantar tuberosity was smoothed with a chisel, and the periosteum similarly smoothed. The fascia was sutured with absorbable surgical suture to the subcutaneous cellular tissue of the flap of skin, and the flap sutured back in place. Blokhin claimed that a lateral incision does not afford good access or good examination of the affected area, and because of insufficient radical surgery, may be followed by recurrence.

All these procedures are unnecessarily mutilating.

Surgical Procedure

In a series of 37 cases in which surgery was clearly indicated, I used the following procedure without having a single recurrence or residual disability. The procedure

Fig. 7—The index finger is able to free the space immediately above the plantar fascia and the apex of the spur.

is comparatively atraumatic and the resulting scar formation at the origin of the plantar fascia has more tensile strength than the normal anatomic attachment of this fascia.

1. A linear incision is made over the medial side of the calcaneus about 2 cm.

above the plantar border (Fig. 6). Usually this is immediately over the medial border of the plantar fascia. The incision is begun at about the posterior border of the calcaneus and continued to about the

Fig. 8—The skin flap is completely freed from the spur with scissors.

anterior third of this bone. The entire incision need be no longer than 5 to 6 cm. The spur will lie immediately under and in the middle of the incision.

2. The incision is continued in depth until the medial border of the plantar fascia is exposed. The right index finger is placed over the superior surface of the plantar fascia just anterior to its origin, and an attempt is made to free this fascia completely across to the lateral side (Fig. 7). Dissection with scissors is continued to free the fascia over and around the spur until it is completely denuded on its superior and inferior surfaces across from the medial to the lateral side (Fig. 8).

3. With the blade of an 8 mm. Andrew's mastoid osteotome placed against the base of the spur, the pressure of the palm of the right hand against the osteotome is sufficient to amputate the spur across the entire surface of its base (Fig. 9). The surface is then smoothed with a Joseph nasal rasp (Fig. 10). The fascia and skin are sutured in layers (Fig. 11), and a compression bandage is applied. No other immobilization is required.

The patient may resume weight bearing with the aid of crutches in about four days.

Fig. 9—With an 8 mm. osteotome the spur is amputated.

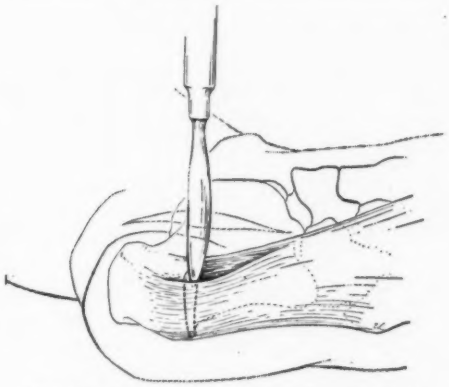


Fig. 10—The surface of amputation is smoothed with a Joseph nasal rasp.

Sutures are removed in 10 to 12 days. Full weight bearing may be resumed in about four weeks after the operation. A sponge-rubber mold, fashioned from a mold of the foot, will stabilize the foot and hasten recovery.

Prognosis

Many have questioned the advisability of surgical removal of a spur, claiming that the spur tends to recur. My experience does not allow me to agree with this opinion, and I find no evidence in the

literature to support such a contention. Such evidence would require a series of cases in which comparison of preoperative,

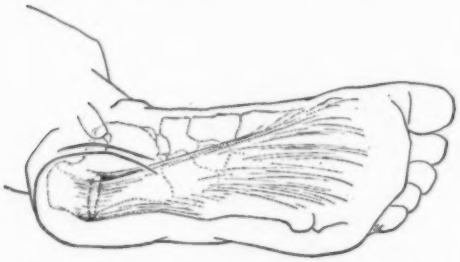


Fig. 11—The fascia and skin are closed in layers.

immediately postoperative, and late postoperative roentgenograms demonstrates a recurrence of the spur. Some roughening of the bone at the point of amputation of the spur does form in some cases; however, I have not seen a single case where this roughening caused symptoms. I have seen two cases, both supposedly having had spurs removed earlier, which showed the spur as smooth in outline as any preoperative spur, yet the plantar tuberosity of the calcaneus was roughened as though it had been chiseled upon. Evidently the operator had missed the spur and removed a part of the tuberosity, thereby causing a roughened surface. The spur which was present could not be a recurrent spur, for, if recurrent, the spur's cortex would have been rough. I removed the spur in each of these two patients, and there has been no recurrence after 15 years.

Report of Two Bilateral Cases

Case 1. A housewife aged 44, height 5 ft. 4 in., weight 209 lbs., complained of intractable pain under both heels, which was unrelieved by numerous appliances or courses of physical therapy. Physical examination and routine laboratory findings were negative. Roentgenograms revealed bilateral calcaneal spurs (Fig. 12U). The spurs were excised by my procedure. The patient made an uneventful recovery and has been free from pain ever since. (Fig. 12L) is a view taken of this patient almost 2 years and 9 months later.

Case 2. A man aged 55, height 5 ft. 10 in., weight 267 lbs., complained of pain in both heels unrelieved by mechanical and physical therapy. Physical examination and routine laboratory findings were negative. Roentgenograms revealed bilateral calcaneal spurs (Fig. 13U). The spurs were excised by the above procedure. Uneventful recovery followed, except for a severe reaction to a prophylactic dose of

Fig. 12U (Case 1) Calcaneal Spur.
Fig. 12L Three years after operation.

penicillin. Sixteen months later (Fig. 13L) he was completely free of pain.

I have seen many patients as long as 20 years after operation for calcaneal spur; all were completely free from pain in the heel. I know of no patient in my series who had a recurrence of symptoms.

Summary

Heel spur is due to mechanical, rather than infectious, factors.

Fig. 13U (Case 2) Calcaneal Spur.
Fig. 13L Three years after operation.

Three types of heel spur are described.

Surgical treatment is indicated only after palliative measures have failed.

The surgical technique described has proved permanently successful in a series of 37 cases.

25 E. Washington St.

References

1. Blokhin, V. N. and Vinogradova, T. P.: *Calcaneal Spurs,* Ortop. i travmatol. 11: 96, 1937.
2. Chang, C. C. and Miltner, L. J.: *Periostitis of the Os Calcis,* J. Bone & Joint Surg. 16: 355, 1934.
3. Costa Bertani, G.: *Flatfoot as a Factor in Producing Inferior Exostosis of the Heel,* Rev. Asoc. med. argent. 53: 455, 1939.
4. Davis, J. B. and Blair, H. C.: *Spurs of the Calcaneous in Strümpell-Marie Disease: Report of 15 cases,* J. Bone & Joint Surg. 32-A: 838, 1950.
5. Gould, E. A.: *Three Generations of Exostosis of the Heel Inherited from Father to Son,* J. Hered. 33: 228. 1942.
6. Griffith, J. D.: *Osteophytes of the Os Calcis,* Am. J. Orthop. Surg. 8: 501, 1901.
7. von Lackum, W. H. and Palomeque, E. J.: *Gonorrheal Spurs a Misnomer,* J. A. M. A. 95: 472, 1930.
8. Steindler, A.: *Orthopedic Operations: Indications, Technique, and End Results,* Springfield, Ill., Charles C. Thomas, p. 216, 1940.
9. DuVries, Henri L., M.D.: *A.M.A. Archives of Surgery,* April, 1957, 74: p. 536-542.

SURGICAL OBLITERATION OF TENDON SHEATH TUMORS CONTAINING RICE BODIES

MARVIN J. LURIE, B.S., Pod.D.*
Maspeth, Queens, N. Y.

PRIMARY tumors of tendons are very rare, the commonest being sarcomas. Primary tumors of tendon sheaths are more common, however, especially the giant myelomata or granulomata and hemangiomata. Tumors of tendon sheaths arise from the cells of the synovial membrane of the sheath.

Tendon sheath cells are modified connective tissue cells similar to those lining the joints and bursae. The tumor cells may be spindle or spheroidal, and may merge from one into the other and form spaces which are comparable to the synovial cavity. Some observers favor the term tenosynovioma. Synovioma may be benign or malignant. The former may be fibrous, cartilaginous, fatty, vascular, osseous or mixed. These may be complicated by the presence of giant cells or foam cells.

Tumors of tendon sheaths are insidious in onset. There is seldom pain. The most constant observation is swelling, which may reach the size of a small orange. The lesion may be localized or extend along the tendon. It usually grows very slowly. Trauma is an important feature, particularly in the cases which show giant cells or "foam" cells. Tumors of tendon sheaths are reddish yellow or gray in color. They are attached to the sheath and may involve a considerable portion of its length on one

*Faculty, New York College of Podiatry Staff, Foot Clinics of New York.

aspect, or may completely surround it. This last statement is of much importance in the case to be cited.

Calcareous material, chondroma, fibroma, lipoma, angioma, and lymphangioendothelioma have been reported. Some tumors resemble chronic tenosynovitis.

A ganglion is a cystic swelling occurring in association with a joint of tendon sheath. It has a fibrous outer coat, an inner synovial layer closely resembling the synovial membrane of a joint, and it contains a thick gelatinous fluid.

The etiology of ganglia is still uncertain and no really satisfactory theory has yet been advanced. Some pathologists regard them as herniations of tendon sheaths or joints, but others consider them to be neoplasms developing from embryonic rests in the periarticular connective tissue, or as resulting from cystic degeneration of the same tissue. There is a close relationship between ganglia and bursae, and it is often impossible to draw a distinct dividing line between them.

Ganglia occur most frequently around the wrist and hand, and the ankle and foot. They are at least five times more common on the dorsal surface than on the palmar or plantar surfaces. As a rule, they grow slowly, although sometimes they appear quite suddenly. The chief symptom, as with other tendon sheath tumors, is swelling, but there may be some weakness or aching of the part involved, along with occasional pain from pressure on adjacent tendons or nerves. Differential diagnosis has to be made from epidermoid and mucous cysts, lipoma, fibroma, neuroma and synovioma. The differential diagnosis between tumors of tendon sheaths and inflammatory diseases, especially the granular type of tuberculous tenovaginitis, is difficult.

At times, tumors of tendon sheaths are seen to contain so-called "rice bodies." Usually, rice bodies are pathognomonic of tuberculosis tenovaginitis. However, for reasons not too clearly defined, rice bodies may appear in perfectly benign tendon sheath tumors.

Rice bodies are small masses, usually oval in shape, and are found attached or loose in a joint. There may be a few of these objects or an enormous number. There has been considerable discussion as to the origin of rice bodies. Two theories are generally accepted as to the origin of these structures: first, synovial fringes that are nipped off; and second, giant cells which come loose in the bursa and cause coagulation about them.

It is generally believed that they are simply an accumulation of giant cells. Fibrin, from the clear or straw-colored fluid, is deposited in layers upon the giant cell nucleus, giving the laminated structure seen on microscopic study. The continuous liberation of giant cells from the sac wall accounts for the large number of rice bodies that are found. In this theory, the origin of the masses is not that of a giant cell extruded from the deeper layers of the sac wall. Some researchers have found rice bodies composed of tuberculous material; that they were at first attached to the wall of a tuberculous sac, and that very probably they were formed from the center of a tubercle.

The case in point is that of a Mrs. G. S., a 150-pound, 44-year-old married white female. Her medical history was negative, except for an appendectomy and cholecystectomy some years previously. The patient's chief complaint was a swelling on the dorsum of both feet. Examination revealed a firm, nodular mass, approximately 2 x 4 cm., on each foot, in the first intermetatarsal space, at the bases of the first and second toes. Locations of the masses were identical on each foot. The masses appeared to be firmly attached to subcutaneous structures, and the skin was freely movable over them. On flexion and exten-

sion of the toes there was slight movement of the masses. Roentgen study showed only soft tissue swelling. A tentative diagnosis of ganglion was made, pending surgery, and the patient was so advised.

On July 2, 1957, the patient underwent surgery for removal of the above-described masses. The areas were scrubbed and draped in the usual manner. Anesthesia was accomplished by local infiltration of 6 cc. of 1% Xylocaine®[1] with 1:100,000 epinephrine into the area on the right foot, and 8 cc. into the area on the left foot. On the right foot, a linear incision, about 4 cm. in length, was made over the mass, extending from the posterior portion of the mass to the anterior, at the bases of the first and second toes. A similarly placed incision was made on the left foot, but subsequently had to be extended into the web between the first and second toes, in order to facilitate complete removal of the mass. This incision was approximately 6 cm. in length.

On exposure, the tumor on the right foot was composed of two distinct masses, attached to and enveloping the tendons of the Extensor Longus Hallucis, the Extensor Brevis Hallucis, the Extensor Brevis Digitorum, and the Extensor Longus Digitorum. The tumor on the left foot was composed of three separate masses, involving the same tendons as the tumor on the right foot.

In both cases, dissection was tedious and painstaking; the technique employed was blunt rather than sharp dissection, using a mosquito hemostat and forceps, rather than scalpel and scissors. In spite of meticulous care, it was not feasible to remove the masses in toto, without rupturing their membranes. Upon herniation of the sacs, there was an escape of gelatinous synovial fluid accompanied by myriads of rice bodies far too numerous to count. This situation obtained in the instances of both the right and left foot tumors.

Removal of the masses and rice bodies was accomplished, and the incisions were closed. In the right foot we used three buried sutures of plain 00 catgut, subcutaneously, and the skin was closed with four sutures of 000 silk. In the left foot, three buried gut sutures were also used, but it took eight silk sutures to close the skin.

The pathologist's report identified the masses as cysts with rice bodies and "tendon tissue compatible with clinical diagnosis of ganglion, with acute and chronic inflammation."

The patient experienced very little, if any, postoperative pain. Edema was moderate on the dorsum of both feet. Dry sterile dressings were applied on the second and sixth postoperative days. Sutures were removed on the ninth postoperative day. Healing progressed uneventfully on the right foot, and was complete by the fifteenth postoperative day. On the left foot, healing was delayed because of exudate. This was treated with Achromycin®[2] surgical powder, and complete healing, closure, and cessation of drainage was accomplished by the thirtieth postoperative day. The patient was seen two months after the date of surgery, and the incision scars appeared pink, healthy, and firm.

The writer wishes to acknowledge the able assistance of Anthony Sarno, Pod.D., during the above described surgical procedure.

7251 Grand Ave.

References

1. Essentials of Orthopedics—Wiles. The Blakiston Co., 1949.
2. The Foot and Ankle—Lewin. Lea and Febiger, 1949.
3. Textbook of General Surgery—Cole and Elman. Appleton, Century, Crofts, 1952.
4. Surgery of The Ambulatory Patient—Ferguson. Lippincott, 1947.
5. Tumors of The Hands and Feet—Pack. C. V. Mosby Co., 1939.

®[1] Astra

®[2] Lederle

HELOMA SURGERY

BERNARD LEVIN, D.S.C., A.C.F.S.
Detroit, Michigan

OF ALL the surgical procedures used by the chiropodical surgeon, heloma surgery probably ranks first among his list of favorites. The reason is that it almost always results in a permanent removal of the excrescence. The word "almost," however, is the reason for this short paper, and I should like to suggest that the failures are frequently due not to poor technique, but to poor appraisal before surgery.

We are fortunate in that our surgeons have devised many surgical procedures for the removal of the heloma. All of these techniques are sound in principle and effective when used where indicated. The failures occur when the wrong procedure is selected for a particular heloma. Nothing is more disconcerting than to have a surgeon try to influence you to use "his special technique" as a routine procedure for all heloma. This surgeon will have failures, for it should be obvious that no one surgical approach to the heloma will serve all cases.

Included in the list of accepted procedures are: the condylectomy, the mid-phalangectomy, the partial mid-phalangectomy, the complete removal of the head of the proximal phalanx, smoothing of the base of the middle phalanx, and certain combinations of the above-mentioned procedures. A mid-phalangectomy combined with a complete removal of the head of the proximal phalanx is not considered good technique. Complete removal of the entire proximal phalanx is also to be avoided.

Skin approaches also vary and should be given ample consideration. The longitudinal linear incisions may be mid-line on the toe, on the dorso-medial or dorso-lateral aspects of the toe, or may be horizontally placed. These incisions may be linear or curved in pairs so as to remove a wedge of tissue including the heloma itself. A decision regarding the extensor tendon must also be made. It may be left intact, severed and resutured, or severed and left alone to lengthen by fibrosis. The size, location and type of skin approach will also vary depending upon the heloma itself. Its size, location, severity and general character will be of influence. The length of the toe, as well as its position (hammered, overlapped, underlapped, fixed, etc.), must also be appraised. With all of these variables to consider, it becomes evident at once that studied evaluation prior to surgery is as important to the success of the procedure as is careful technique on the part of the surgeon. It might be noted here that even the most detailed x-ray survey is often of little practical value. Experience has shown that these surveys fail to show the true extent of the bony pathology. A decision for or against heloma surgery should not rest on the x-ray evaluation alone.

The least complex of all the heloma procedures is probably the simple condylectomy. This technique, however, should be reserved for only the mildest helomas and should be done where the toe is in good position. Note that some regeneration may occur, and that this may be sufficient to produce another heloma.

The mid-phalangectomy is a common procedure. It is especially useful where the phalanx is small, and should not be used where the phalanx is long, for an "hour glass" or "coke bottle" toe may result. The mid-phalangectomy should be considered where considerable shortening of the toe is a desired effect. Where a middle phalanx is long, partial removal of the bone may be done, providing sufficient bone is left to function without difficulty. A combination mid-phalangectomy and simple con-

dylectomy of the head of the proximal phalanx is a frequently performed technique.

Complete removal of the head of the proximal phalanx along with some trimming of the base of the middle phalanx is probably the most common type of heloma surgery. This combination will give good protection against recurrence of the heloma and at the same time will provide a good cosmetic result.

Skin incisions, as previously mentioned, can serve useful purposes in attaining certain desired results. A dorsal horizontal wedge, when closed, will often remove sufficient tissue to straighten a contracture of the toe. Longitudinal wedges, including the heloma, are useful when a thinner toe is desired, or when a "fat" toe is expected to result from the surgery. These wedges, when carefully done, will present a nice linear incision upon closure. Incisions, of course, should be planned so as to avoid shoe pressure. On second, third and fourth toes this will probably be at either the dorso-medial or dorso-lateral borders. On fifth toes this may be mid-line on the toe, especially if the heloma is laterally located.

As for the extensor tendon, it is felt that this should be left intact wherever possible. If cut, it should be resutured before closing. A flail toe will result where the tendon is left cut. This, however, will fibrose in time. Where dorsiflexion of the toe occurs at the metatarso-phalangeal articulation, a separate tendon resection should be performed proximal to that joint, removing as large a piece of tendon as is possible. Remember that the short flexor tendon may also be involved in the contracture and must also then be resected.

I have deliberately omitted a discussion of the techniques for these procedures in this short paper. It is my intention to indicate that there are many factors to be considered in choosing the proper procedure and that successful heloma surgery without adequate prior appraisal is just pure luck.

14110 Gratiot Avenue

PRELIMINARY EVALUATION OF CHIROPODICAL SURGERY

HUGH CREDILLE, B.S., D.S.C.; W. M. FOO, B.S., M.H.A., D.S.C.;
A. J. HARLER, D.S.C.; R. J. HOLMES, D.S.C.;
RICHARD LaVEAU, D.S.C.; WM. REED, D.S.C.;
JAMES WOOLSEY, D.S.C.
Chicago, Illinois

IN THE PAST, there has been a decided lack of statistical data available to the chiropodist for evaluation of podiatric types of "elective" surgical procedures done on the human foot. The significance of such evaluative criteria for the profession is obvious. The research project here presented* was designed as a pilot survey to serve as the first steppingstone in this direction.

Several inconsistencies and gaps in data limited the original scope of this research. In addition it must be remembered that the surgeries examined were performed at the Illinois College of Chiropody and Foot Surgery by many different students under the supervision of several clinical instructors. In combination these things provide too many uncontrolled variables for the data needed for this type of study. Therefore, the data reported herein can at best be considered as indicative only. It is to be hoped that in future years a more definitive study will be carried out with more finite classifications of the surgeries and larger samplings.

* Project conducted under supervision of L. R. McCain, D.S.C., F.A.C.F.S., Surgery Department, Illinois College of Chiropody.

The Method

All available records of surgery performed at the Illinois College of Chiropody and Foot Surgery were collected for consecutive years from 1952-1955. In total over 200 cases were processed. These approximated 1/3 of all operations performed in these years. The operations included procedures for correction of hammered toes, heloma molle, heloma durum, incurvated nails, exostoses, neoplasms, cysts, bursae, verrucae, etc. In a few instances those operations that occurred in small numbers are not reported to avoid further distortion of a small statistical base.

For simplification the operations considered were classified into four major groups:

1. Bone abnormalities, e.g.: enlarged condyles or exostoses.
2. Joint resection, e.g.: removal of head of proximal phalanx.
3. Nail corrections, e.g.: incurvated nail.
4. Growths, cysts and bursae.

Each record of each operation was processed in the following manner:

1. The patient's phone number was called.
2. If the patient was contacted he was asked if in his opinion the operation had given satisfactory results.
3. If the patient reported unsatisfactory results, he was asked to return for re-examination by a clinical instructor at the college. A standardized form was developed for this examination in order to provide comparable data.

The following data was obtained:

Bone Abnormalities

Seventy-three percent of the 11 cases contacted reported satisfactory results by telephone contact. Three or 27% of these cases reported unsatisfactory results. Only one of these three came in for re-examination but was judged to be a good result by the clinical examiner.

The patient presented no gross indications of failure in technique or lack of relief of symptoms by either physical or X-ray examination.

Growths, Cysts and Bursae

Six of the seven cases or 85% of these cases were satisfied with the surgical results.

The one dissatisfied case contacted did not respond to recall and consequently was not re-examined.

Joint Resections

Twenty patients were contacted who had this type of operation. They all (100%) reported satisfactory results with complete relief of symptoms; no aggravation of existing foot conditions at the time of the operation; and no complications arising after the time of the operation.

Only 20, less than one-third, of the 64 case records taken for sample were contacted. The good results are, therefore, not conclusive because of the small numerical group.

Nail Corrections

Of this group 62% reported satisfactory results. Nine patients (38%) stated they had unsatisfactory surgical results. Only three of this group of nine patients appeared for re-examination. All three were judged good by the clinical examiner.

One of the re-examined cases was a patient who was apprehensive because she had not adhered to post-operative instructions. Another was unhappy with the cosmetic result, but satisfied with the symptomatic relief. The third was a mentally deficient person who had been unable to express himself by telephone.

The group of patients having nail corrective work represented the largest group in the four major surgical classifications studied and had the highest percentage of contact. In this particular instance, the patients implied that the cosmetic result was as important as were the correction of the pathology and relief of pain. This, perhaps, explains the lowest percent of satis-

TOTAL CASES SURVEYED CLASSIFIED SURGICALLY AS SATISFACTORY OR UNSATISFACTORY

Surgical Classification	Total Cases	Patients Contacted				
		No. Satisfactory		Unsatisfactory		
		No.	%	No.	%
1. Bone Abnormalities	50	11	8	72.7	3	27.3
2. Joint Resections	64	20	20	100.0	0	00.0
3. Nail Corrections	67	24	15	62.5	9	37.5
4. Growths, Cysts & Bursae	21	7	6	87.1	1	14.3
Total	202	62	49	79.0	13	21.0

TOTAL UNSATISFACTORY CASES BY SURGICAL CLASSIFICATION SHOWING RE-EXAMINATION RESULTS

Surgical Classification	Total Dissatisfied	Number Re-examined		
		Total	No. Judged Good	No. Judged Poor
1. Bone Abnormalities	3	1	1	0
2. Joint Resections	0	0	0	0
3. Nail Corrections	9	3	3	0
4. Growths, Cysts & Bursae	1	0	0	0
Total	13	4	4	0

faction (62%) as expressed by this group collectively in comparison to the other three groups.

Summary

In the four major classifications discussed it would appear that the percent of satisfactory results rendered by chiropodic surgical procedures ranged from 62% to 100%. The average percentage for all chiropodic surgical operations performed was 79% or 49 of the 62 total cases contacted by telephone. Of the 13 cases that reported dissatisfaction with their operations, only four came in for re-examination. In each instance, the patient was judged to have good results in that the surgery accomplished relief of symptoms caused by the original condition. In most instances explanations and answers to questions put by the patient clarified the problem to the satisfaction of the patient.

Conclusion

This survey presents some indicative data. It is limited by the very small statistical sample and by the lack of controls as presented in the surgical reports.

Gross evaluations show that, except for corrective nail operations, chiropodic surgery has at least a 79% satisfactory result. There were strong indications that many dissatisfied patients were those who were apprehensive over their own failure to comply with the necessities occasioned by a surgical procedure. It was even more strongly implied that the patient's subjective analysis of his own case was not supported in fact from the clinical point of view.

The impressions gained by the surveyors would further complement this picture since in many cases the patients expressed a sincere attitude of thankfulness for having undergone the "elective" type of surgery, for relief of foot pain. Until such time that more substantial data can be formulated these figures are presented as representative values and criteria for chiropodic surgery.

1327 N. Clark St.

The smile on your face is the light in the window that tells people you are at home.

A church weekly

CLINICAL USES OF PROMETHAZINE IN PODIATRIC MEDICINE AND SURGERY

G. E. DACRE, D.S.C.
Sacramento, Calif.

PROMETHAZINE®[1] is a drug possessing (1) anti-histaminic properties[1], (2) anti-emetic properties,[2,3] and (3) the ability to enhance the analgesic effect of narcotics and the sedative effects of barbiturates.[4] The compound is a particularly versatile one, with numerous applications in surgery and obstetrics[5,6,7] as well as in the general practice of medicine. It seemed desirable, therefore, to evaluate the clinical usefulness of promethazine in podiatry and foot surgery.

Report of Cases

Three groups of patients, totaling 200, were observed in this study. One group of 110 consecutive, unselected patients, aged 10 to 73 years, were subjected to more or less extensive minor surgical procedures. A second group of 30 postoperative cases and outpatients received promethazine (1) as an adjunct to narcotics given for relief of pain or (2) to supplement sedatives administered for insomnia associated with podiatric disorders. The drug was given to a third group of 60 patients exhibiting allergic reactions. Table I presents a summary of the groups evaluated.

Operative Procedures

Method: In the more extensive surgical procedures, the anesthesia was administered by a qualified anesthesiologist. Blood pressure, pulse rate, respiratory rate, and condition of the patient were observed throughout the procedure. Response to promethazine medication the night before surgery was recorded in the nurse's notes, and postoperative responses were noted on recovery room records.

These patients (fifty) received promethazine (1) the night before operation, for psychic sedation and to promote sound sleep, (2) 45 minutes before procedure, as a preanesthetic medication, and (3) immediately after completion of surgery, for control of postoperative pain, discomfort, edema, and emesis. The night prior to surgery all patients were given 25 mg. promethazine with 64 mg. of pentobarbital. Before anesthesia, each received 50 mg. promethazine intramuscularly and 75 to 100 mg. of meperidine hydrochloride plus 0.4 mg. atropine sulfate intramuscularly, in two separate injections. Postoperatively, 25 mg. promethazine was administered intramuscularly, with 75 to 100 mg. meperidine hydrochloride.

Forty of 50 surgical patients received thiopental sodium as a continuous intravenous drip. In the remaining 10 patients a spinal anesthesia with tetracaine hydrochloride and 10 percent dextrose solution was employed with thiopental sodium maintenance.

Sixty patients undergoing less extensive surgery received 25 mg. promethazine orally the night before procedure for sedation and 50 mg. promethazine, with 50 mg. meperidine hydrochloride, intramuscularly 45 minutes before procedure as preoperative medication.

All these less extensive surgical procedures were carried out in the office with local anesthesia using 2 percent solution of Xylocaine Hydrochloride®[2] and 1:100,000 epinephrine solution, with 150 USP units of Hyaluronidase®[3] added to facilitate spread of the local anesthesia.[8]

Results: All 110 surgical cases slept well under promethazine sedation the night be-

®[1] Promethazine hydrochloride [10-(2-dimethylamino-iso-propyl)-phenothiazine] is available from Wyeth Laboratories. Inc., Philadelphia, Pa., as Phenergan® hydrochloride.

®[2] Astra.

®[3] Available as Wydase® from Wyeth Laboratories, Inc.

fore procedure. Surgical patients arrived in the operating room quiet, drowsy, and often dozing, yet easily aroused. When awakened, all were mentally alert and cooperative. Nausea was absent preoperatively.

The anesthesiologists and author both noted smooth induction under general anesthesia, as well as reduced anesthetic requirements for maintenance. No alterations in blood pressure, pulse rate, and respiratory rate and depth were observed.

TABLE I

PROTOCOL OF 200 PODIATRIC PATIENTS

Total Number Patients	Diagnosis	Number of Patients	Type Procedure
110	Surgery, General or Spinal Block Anesthesia	50	
	Hallux valgus		Bunionectomy
	Sesamoidalgia or bi partit sesamoids		Sesamoidectomy
	Exostosis, hypertrophied condylar process		Condylectomy of head and neck osteotomy
	Sub ungual exostosis		Exostectomy
	Calcaneal exostosis		Exostectomy
	Complete fracture metatarsal shaft		Open reduction
	Metatarsus primus varus with hallux valgus		Lapidus procedure
			Metatarsal base cuneiform arthrodesis
	Surgery, Local Anesthesia	60	
	Nevus		Excision and biopsy
	Contracted digit (Hammer toe)		Tenotomy
	Ganglion or cysts		Ganglionectomy
	Paronychia		Incision and drainage
	Onychocryptosis		
	Onychogryphosis		Wedge resection and plastic lip remodel
	Onychomalacia		
	Xanthoma		Excision
30	Insomnia associated with orthopedic treatment, general pain, psychic sedation	30	General sedation and to augment narcotic barbiturates and anesthesia
60	Allergic reaction to antibiotics	5	Relief of allergic symptoms
	Allergic reaction to other drugs	20	
	Allergic reaction to cosmetics	8	
	Allergic reaction to insect bite	1	
	Urticaria	25	
	Angioneurotic edema	1	

After awakening in the recovery room, patients were cooperative and responsive to command. The recovery room staff commented on the complete absence of nausea and emesis following general and regional anesthesia. Postoperative recovery in all cases was rapid and without complications.

Patients undergoing surgery in the office were cooperative and sedated. Many slept throughout the entire procedure. Postoperative pain was reduced, and smaller doses of analgesics were required.

patient followed directions. In two of eight patients with allergic reaction to constituents of cosmetic preparations, diminution of symptoms was delayed or not apparent. However, both patients admitted taking the drug irregularly and omitting one or more doses.

Twenty-five patients with allergic reactions to antibiotics or other drugs responded well. In 19 of 25 patients (75 percent) with urticaria, symptoms disappeared within 48 hours after starting medication.

TABLE II

RESPONSE TO PROMETHAZINE OF 60 ALLERGIC CONDITIONS

Symptoms	No. Patients	Promethazine Medication		Response, %	
		Dosage, mg.	Route	Good	Poor
Allergic reaction to antibiotics	5	25-50 mg.	IM	100%	—
Allergic reaction to other drugs	20	25-50 mg.	IM	100%	—
Allergic reaction to cosmetics	8	cream*	cutaneous	75%	25%
		25 mg.	oral		
Allergic reaction to insect sting	1	50 mg.	IM	100%	—
Angioneurotic edema (unknown etiology)	1	50 mg.	IM	100%	—
Urticaria (unknown etiology)	25	25-50 mg.	Oral	75%	25%

*Promethazine hydrochloride cream, available from Wyeth Laboratories, Philadelphia, Pa., contains 2 percent 10-(2-dimethylamino-iso-prophyl)-phenothiazine hydrochloride in a water-soluble base.

Enhancement of Analgesic and Sedative Action

Thirty patients were given 25 to 50 mg. of promethazine as an adjunct to analgesics and sedatives. In our hands, as with many other investigators, promethazine reduced the amount of analgesic required to control pain. No untoward effects from local anesthetic were noted.

Control of Allergic Reactions

Sixty patients received promethazine in dosages shown in Table II to control allergic symptoms of varying etiology.

Response to promethazine medication was satisfactory in all cases where the

Response to promethazine in one patient suffering severe allergic reaction to insect sting was dramatic, as the following case history illustrates:

> Case 1: A white female, aged five years, was seen for treatment of multiple wasp stings involving both feet between the fourth and fifth toes. The child arrived in a semicomatose state. According to the mother, her daughter had stepped barefooted into a wasp nest less than 10 minutes previously. No prior history of sensitization could be elicited.
>
> Severe angioneurotic edema of the eyelids and lips was present, and generalized

facial edema developed rapidly. Mild dyspnea existed, and early cyanosis was observed.

The patient was given 0.5 cc. of a 1:1000 solution of epinephrine, injected subcutaneously, and 50 mg. promethazine hydrochloride intramuscularly. The progressive respiratory obstruction was arrested in minutes. Within one hour acute symptoms diminished and edema receded somewhat. Each stinging apparatus was removed from her wounds, and palliative wet dressings were ordered. Promethazine tablets, 25 mg. twice daily, were prescribed and the child was sent home and to bed. On examination of the patient at home the following day, all symptoms had disappeared and no further treatment was necessary.

Comments and Summary

No side effects of promethazine were observed in our series of cases. In our experience, oral administration was found to produce more prolonged action, in equivalent dosage, than intramuscular injection. Analgesic and anesthetic requirements in surgical procedures were reduced when promethazine was administered as part of the premedication.

The satisfactory patient response and absence of side effects indicates that promethazine is a valuable adjunct to the preoperative preparation, anesthesia, and postoperative care of the podiatric patient. The drug possesses merit as an adjunct to analgesics or sedatives administered in treatment of food disorders. The antihistaminic action of promethazine makes it a valuable therapeutic agent in the management of allergic reactions in the general practice of foot medicine.

2401 Eye Street

References

1. Dillon, G. P.: *Clinical Evaluation of Promethazine for Prevention of Postoperative Vomiting,* Amer. Pract. & Dig. Treat., *8:* 1571-75 (Oct.) 1957.
2. Sadove, M. S., & Frye, T. J.: *Preoperative Sedation and Production of a Quiescent State in Children,* J.A.M.A., *164:* 1729-33 (Aug. 17) 1957.
3. Watrous, W. G.: *Promethazine in Clinical Anesthesia,* Anes. & Analgesia, *36:* 38-45 (Sept.-Oct.) 1957.
4. Silbert, N. E.: *Phenergan Hydrochloride—a New Antihistamine,* Ann. Allergy, *10:* 328-34 (May-June) 1952.
5. Sadove, M. S.: *Promethazine in Surgery,* J.A.M.A., *162:* 712-15 (Oct. 20) 1956.
6. Light, G. A., Morch, E. T., & Engel, A.: *Promethazine (Phenergan) Hydrochloride as an Adjunct to Anesthesia,* J.A.M.A., *164:* 1648-50 (Aug. 10) 1957.
7. Stearns, A. B.: *Promethazine Hydrochloride for the Control of Nausea and Vomiting During Spinal Anesthesia,* Ill. Med. J., *112:* 267-69 (Dec.) 1957.
8. Moore, D. C.: *The Use of Hyaluronidase in Local and Nerve Block Analgesia Other Than Spinal Block: 1520 cases,* Anesthesiology, *12:* 611-26 (Sept.) 1951.

Whoever appeals to authority applies not his intellect but his memory.

Leonardo

OS INTERMETATARSEUM
Case Study and Report

LORY WATERS, D.S.C.
Inglewood, Calif.

MAN has departed greatly from the primitive mammalian type in the structure of his brain and trunk, yet in the elements which enter into the formation of his limbs, he has retained more of the ancestral mammalian features than many other mammals. He retains the original number of digits; the bones of his foot are much less specialized than those of the horse. The skeleton of his lower extremity has been extensively modified for his orthoplantigrade posture; yet under all the adaptive features one can see very clearly the outlines of the most primitive form. He comes from a stock which led an arboreal existence almost from the dawn of the mammal.

The manner of development in the vertebrate embryos indicates that the limbs were not solely outgrowths from the paravertebral or axial system but in every case include considerable, or perhaps are all, somatopleure. The rudiments of the extremities appear in human embryos about the end of the third week. During the fourth week the foot is differentiated from the leg. Ossifying centers for the forefoot appear at the ninth week. A primary center for each metatarsus appears in the ninth week of foetal life, being well ossified at birth. A secondary center for each appears at three years in males and at two years in females. The epiphysis for the first metatarsal is at the base or proximal end and at the head or distal end in the other four metatarsals. Epiphyseal fusion is complete at eighteen years in males and fifteen years in females.

An abnormal or extra center of ossification may make its appearance and the resulting bone may remain discrete. We find that occasionally there is a fifth articular surface at the base of the second metatarsal for contact with the base of the first metatarsal and this may be the developmental origin of the case in point.

A white female, age 26, presented a condition of hallux valgus. Severe pain was elicited throughout the foot on weight bearing and upon palpation of the dorsum of the foot at the base of the second metatarsal, radiating forward into the first interosseus space. This discomfort was in addition to the typical symptoms associated with hallux valgus. A roentgenogram study revealed the presence of an unusual bone formation. It apparently stemmed from the dorsi-medial aspect of the second metatarsal base and extended anteriorly into the first interosseus space. Dimensions were approximately 3.5 x .5 cm. right and 3 x .5 cm. left, (Fig. 1).

Fig. 1. Os Intermetatarseum of Patient (proband)

Fortunately, members of the patient's family were available for examination and the following study was made:

1. Patient (proband), age 26, bone formation present
   A. Female child, age 7, bone formation present

B. Male child, age 6, positive left, possible right
C. Female child, age 18 months, possible
D. Female child, age 6 months, negative

2. Sister, age 24, bone formation present (Fig. 2)
   A. Male child, age 7, negative questionable
   B. Male child, age 6, negative
   C. Male child, age 3, negative
3. Mother, age 50, bone formation present (Fig. 3)

All examined presented other familial characteristics which are not pertinent to this paper.

The patient was considered a surgical problem and was admitted to the hospital. Routine physical and laboratory examination was made. The following procedure was performed under general anesthesia. A bloodless field was maintained with a pneumatic cuff applied above the knee.

Fig. 2. Os Intermetatarseum of Sister

A longitudinal incision was made through the dorsal skin extending from the basal second metatarsal-cuneiform articulation, distally to the second metatarso-phalangeal joint and within the first interosseus space. The incision was carried deep by sharp dissection. The bone segment now partially exposed was carefully dissected from its surrounding soft tissue attachments. Using a No. 12 osteotome and mallet, the bone was resected from its attachment at the dorso-medial aspect of the base of the second metatarsal in toto. The area of attachment was rounded with rongeur to conform to the basic form of the metatarsal base. Chromic and dermal .000 sutures were used to close tissue in layers.

A second procedure performed was as follows: A semi-elliptical incision was made through skin, dorso-medially over first metatarso-phalangeal joint. The incision was carried deep by blunt dissection to expose the joint capsule. A "U" or horse-shoe incision was made into the capsule and the resulting flap was retracted towards the base of the proximal phalanx. Through this exposure the hypertrophied areas of the head of the first metatarsal, medially, dorsally and plantarly, were removed. This was accomplished with the use of chisel and rongeur. The unexposed lateral portion of the joint capsule was forcibly stretched to reduce strain on, and facilitate repair of the medial flap, also bringing the great toe into better alignment. Tissue was closed in layers. Ace®[1] bandage was applied over sterile Telfa ®[2] dressings to control post-operative edema. Demerol®[3] 100 mg. q.4h was ordered for pain. The patient dangled feet on the second post-operative day, weight bearing with help on the fourth day, discharged from the hospital on the fifth day. At this time, patient was semi-invalid using crutches for limited activity. Skin sutures were removed on the seventh day. Three months later there is no pain or swelling and patient is completely active. There is slight limitation of dorso-flexion of the great toe but it is of a lesser degree than existed pre-operatively.

There is some question as to the final diagnosis of the bone formation in this

---

®[1] Becton & Dickinson.
®[2] Curity.
®[3] Winthrop Laboratories.

case. Is this fragment supernumerary, rudimentary or accessory? According to Dorland, supernumerary is in excess of the regular or normal number; rudimentary is imperfectly developed; accessory is supplementary or affording aid to another similar

Fig. 3. Os Intermetatarseum of Mother

and generally more important thing; Os intermetatarseum is an occasionally occurring accessory bone between the proximal ends of the first and second metatarsals. Schuster states that the os intermetatarseum is situated between the first and second metatarsals; may be separate or an elongation of the internal cuneiform or fused to the base of the first or second metatarsal. In checking the available literature we find that a supernumerary metatarsal is usually of a polydactyl nature including extra digits. The author of this article feels that in the final analysis, this is an accessory bone, namely the os intermetatarseum.

The os intermetatarseum was first described by Gruber in 1856. Statistically, Quereilhac in an examination of 445 cases found 0.2% or seven cases and compares his findings with Phitzner's works which show a 10% of 840 dissections. Shands examined 404 x-ray files taken from the Emergency Hospital, Washington, D. C. and found 1.24% or 5 cases. He also states that according to Dwight the percentage is 10%. It is interesting to note that the importance attached to accessory bones is usually of a medico-legal nature, due to the possibility of mis-diagnosis in injury. In the case presented here, the condition is significant by being symptomatic and also is an etiological factor of a foot imbalance.

405 W. Manchester Blvd.

References

1. Dean Lewis: *Practice of Surgery*, W. F. Prior Co., Inc. 1955.
2. O. N. Schuster: *Foot Orthopedics*, J. B. Lyon Co. 1939.
3. A. R. Shands, Jr.: *The Accessory Bones of the Foot*, South. Med. & Surg., 93:326. May 1931.
4. T. Horwitz: *Supernumerary Metatarsal Bone and Toe*, Am. J. Surg., 50:578. Dec. 1940.
5. H. Quereilhac: *Huesos Supernumerarios del Pie*, La Presa Med. Argent., 29:387, Mar. 1942.
6. W. F. Prior Co.: Consulting Bureau Service.
7. W. A. Newman Dorland: The American Medical Illustrated Dictionary, W. B. Saunders Co. 1951.
8. J. C. Boileau Grant: *A Method of Anatomy*, Williams & Wilkins Co. 1948.
9. Henry Gray: *Anatomy of the Human Body*, Lea & Febiger. 1944.
10. George McClellan: *Regional Anatomy in Its Relation to Medicine and Surgery*, George McClellan. 1894.
11. Phillip Lewin: *The Foot and Ankle*, Lea & Febiger. 1949.
12. L. Waters: *The Embryological Development of the Human Foot*, a term paper. 1940.

Next to the originator of a good sentence is the first quoter of it.

Emerson

CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

AINHUM: A Case Report

E. B. ROSS, B.A., D.S.C.
Columbia, S. C.

A NEGRO woman, approximately 55 years old, consulted a chiropodist in this city for treatment of a painful 5th toe. This toe was evaluated by the author and the referring chiropodist as ainhum or dactylolysis spontanea. Further assurance of proper diagnosis of this unusual case was made by a consulting dermatologist of wide experience who stated that this was the first case of ainhum that he had seen.

Ainhum is a condition which eventually will result in spontaneous amputation of the involved digit (dactylolysis spontanea) at an area of unexplainable construction. The etiologic factors are considered to be parasitic or viral.[1,3] This seems unlikely in the sense that we think of parasites and virus as being migratory in the body, i.e., toward/or in a body system. Why these organisms should localize to such a small area as the tissue approximating the phalanges of the lesser digits is perplexing.

The differential diagnosis of this condition from other lesions of the toes is comparatively easy, but a hasty diagnosis of an inflamed heloma durum complicated with a sinus or vascular gangrene could lead to much embarrassment.

The Negroid race is the prime sufferer of the affliction with chiefly the 5th toe being involved. This condition is rather uncommon in this country, even in the Southern U. S., but is of common occurrence in Africa, Brazil, and the West Indies. Ornsby and Montgomery[1] relate that the condition has been seen in whites and on fingers as well as toes.

Figure 1 gives the appearance of the toe when first examined. The patient also stated her father had similar trouble prior to his death. According to the patient the toe began to give her discomfort five months previously. With the amount of tissue destruction present this did not seem feasible.

Fig. 1. Ainhum of fifth toe. Inset is the surgically excised toe.

The entire toe was flexible and flabby. The only rigidity encountered was at the constricted area. The terminal portion of the toe was bulbous with slight erythema causing the nail to be partially obscured by edema. A fibrous ring of subdermal cicatrization was palpated just proximal to the ulceration and hyperkeratosis. The characteristic constricting ring was evidenced with slight ulcerations bordered

with hyperkeratosis. This hyperkeratotic area would have eventually been the site for the spontaneous amputation.

Treatment:

The affected digit was surgically excised. (Inset Fig. 1.) The area of ulceration and hyperkeratosis was debrided and the field scrubbed with Zephiran Chloride.®[1] After debridement and on forcing the toe in hyperextension, the Flexor Digiti Quinti tendon was easily exposed. The incision was made proximal to the constricting band and completely circling the toe. No bone forceps or saw was needed at this point because absorption had already occurred. When the toe was removed a hollow pit was evidenced where the proximal phalanx had been prior to absorption. In cleansing the wound, sharp bone spicules or sequestra were felt, that had not been completely absorbed, attached to the metatarsophalangeal capsule. These were removed or rounded off using caution not to injure the capsule.

The toe was sent to a laboratory for pathological studies. The report follows:

Gross:

The toe is 3.5 cm. long. The distal end is 2 cm. wide and 1.5 cm. thick, 2.3 cm. proximal to the distal end there is constriction so that the toe here is only one cm. in diameter. At this point the proximal part joins the distal part at an angle of about 45 degrees. The surface forming the acute angle is superficially ulcerated. This involves the entire medial surface and extends partly on to the plantar surface. Proximal to this, tissue 0.5 cm. long is attached. The margin of excision here measures 2 x 1.3 cm. There is no bone in this area and no bone is present beneath the area of ulceration. A very small amount of bone measuring about 0.3 x 0.6 cm. is present just distal to the area of constriction. This is considerably softer than normal. On the plantar surface just distal to the constriction there is an area of hyperkeratosis about one cm. in diameter.

®[1] Winthrop

Microscopic:

In the area of constriction there is dense subepithelial fibrosis with scattered small fragments of necrotic bone and a small amount of osteoid tissue. The epithelium covering this area is markedly thickened and hyperkeratotic with pronounced parakeratosis. The epithelium covering the plantar surface is similar, but the changes here are less pronounced.

Diagnosis: Ainhum

Two weeks after the amputation the sutures were removed. The healing and coaptation were excellent. The patient was free from all complaints.

The author acknowledges, with thanks, the aid of Dr. Gene Clark and Dr. Leon S. Bryan in the preparation of this report.

535 Harden Street

References

1. Ornsby & Montgomery: Diseases of the Skin, p. 687, 8th ed., Lea & Febiger, Philadelphia, Pa., 1954.
2. Hauser, Emil D. W.: Diseases of the Foot, p. 366, 2nd ed., W. B. Saunders & Co., Philadelphia, Pa., 1950.
3. Gross, Reuben H.: Modern Foot Therapy, p. 437, Modern Foot Therapy Publishing Co., 1948.

FOREIGN BODIES

A Case Report

H. S. ESTERSOHN, D.S.C.
Newark, N. J.

ON SEPTEMBER 14, 1953, a twenty-seven-year-old white female presented herself for treatment. She had a slight edematous area along the plantar of the right first metatarsal head.

History

On or about August 22, 1953, while walking along the beach, the patient had

stepped on a dead fish, causing two lacerations which bled quite profusely and resulted in a great deal of pain. Within two weeks the area had healed, however, the patient still complained of pain.

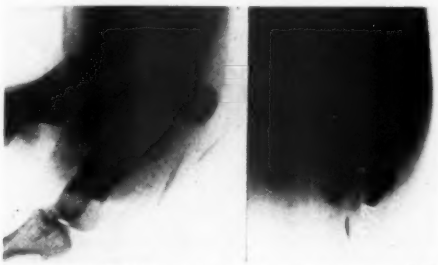


Fig. 1. Radiographs of foot showing fish bones or fins. Left is lateral projection; right, axial projection.

Examination

Inspection revealed an edematous area around the plantar of the first metatarsophalangeal articulation. Palpation revealed two deep-seated indurated masses which, upon pinching, presented a sharp pain. However, no pain resulted from direct pressure.

X-ray examination (Fig. 1) revealed the presence of two small bones, or fins, under the base of the proximal phalanx of the large toe and partly under the first metahead. Surgery was suggested and scheduled. Laboratory findings were normal.

Surgical Procedure

The indurated areas were marked, the foot was scrubbed and prepared for surgery. Two cubic centimeters of Xylocaine®[1] were infiltrated into the area. An incision, one and one-half millimeters long, was made over the pre-marked area, following the lines of the skin cleavage.

The incision was deepened and retracted. Since these bones were transparent, they were difficult to see. Exploration was accomplished by probing and upon hearing a click, hemostats were then used to remove the bone.

A second incision was made over the premarked area at a point more lateral and distal to the first. The second bone was then removed in the same manner.

Two single interrupted sutures (000 dermal) were used for each skin closure and a sterile dressing was applied. Five days later, the stitches were removed and the area redressed. Three days later, the patient was discharged.

103 Lyons Avenue

®[1] Astra

SUBUNGUAL EXOSTOSIS: A Simplified Surgical Procedure

R. KENNETH SANDEL, D.S.C., F.A.C.F.S.
Columbus, Ohio

A SUBUNGUAL EXOSTOSIS may at times be confused with a granuloma pyogenicum, ingrown nail, simple fibroma, or malignancy. The most common site of the lesion is the tibial or medial margin of the first toes. However, it is not uncommon on the second or third toes. It usually follows mild or severe trauma to the distal phalanges.

It is therefore necessary to radiograph the toe in two planes to diagnose a subungual exostosis. In the lateral x-ray view the lesion appears as a mushroom type formation arising from the dorsal aspect of the distal phalanx. The pedunculated attachment to the phalanx is usually fibrocartilaginous or osseous depending on the length of time the lesion has been present.

Treatment:

The surgical excision of the exostosis is the treatment of choice, performed under aseptic technique, and a bloodless field.

The simplest atraumatic technique is the gentle removal of the entire nail with minimal injury to the nail bed, by using a dura elevator or the ungual elevator by Lawrence Frost.[1] Starting at the line of de-

marcation between the growth and the normal nail bed shell out the mass down to and including its attachment to the phalanx. Curette the base and trim away any redundant tissue remaining. Apply a sterile dressing coated with a topical antibiotic such as Spectrocin,®1 Bacitracin,®2 or Neo-polysin.®3 My suggestion is not to use penicillin as many patients are sensitive to this drug when applied topically. Apply a firm roller bandage to control hemorrhage. Healing takes place by third intention following the organization of the clot in the cavity with complete healing in three to four weeks. A normal nail will replace itself over the area. A modification of the above is the removal of only a portion of the nail in a generous area surrounding the lesion, followed by the same surgical technique as described above.

Note:

In lesions of the lesser toes complete removal of the nail prior to the removal of the subungual exostosis is the procedure of choice. In the writer's opinion, the removal of this type lesion through a fish mouth incision should not be used, since sloughing of the tissues and flap, as well as gangrene of the toe, may follow its use.

1466 Northwest Blvd.

®1 Squibb
®2 Pfizer
®3 Pitman-Moore

Reference

1. Frost, Lawrence, D.S.C., F.A.C.F.S.: *Atraumatic Nail Avulsion with a Novel Ungual Elevator;* J.A.P.A., 48, 2:51-53; February, 1958.

A PROPHYLACTIC SURGICAL PROCEDURE

A. G. HELLER, JR., D.S.C.*
Elizabeth, N. J.

"Moles located on the feet, genitals, and under the nails are considered to be extremely dangerous . . . it is only logical to consider the excision of moles as a prophylactic measure." [1]

A mole may be described as a pigmented macular or papular nevus of the skin, varying in size, location and pigment. Pathologically it may be an intradermal lesion in which case it is generally benign. The nevus considered to be premalignant is the junction nevus, or that which has nevus cells growing actively at the dermal epidermal juncture. The clinical appearance of these tumors may be identical and it may not be possible therefore to predetermine the ultimate state of pigmented nevi.

According to Ferguson, there is evidence that at least 50% of malignant melanomas arise from pre-existing nevi. It is recognized that chronic minimal trauma such as caused by shoes may be responsible for the production of malignant lesions from pre-existing moles. Since it is difficult or impossible to clinically determine a malignant change taking place in what might appear to be a harmless lesion, and since malignant melanomas are rapidly fatal, it is good prophylactic medicine to remove moles when they are found on the feet. When moles undergo changes such as bleeding, ulceration, itching, crusting, increase or change in pigment or size, or elevation of a flat lesion, there should be no delay in treatment.

Procedure for Removal of Moles

That trauma to an existing pigmented nevus may be the cause of malignant degeneration is widely recognized. It must also be considered that an improper or too conservative procedure may likewise precipitate the formation of a malignant melanoma having a rapidly fatal termination. The employment of electro-cautery, radiation, keratolytic chemicals, dry ice and the like may only serve to further stimulate the nevus cells. The procedure of choice is surgical excision.

Following routine aseptic precautions,

* Chiropody Clinic, Elizabeth General Hospital; Courtesy Staff, Memorial Osteopathic Hospital, Elizabeth, N. J.

the skin may be anesthetized by infiltration of a local agent (2 cc. will usually suffice). The skin is then incised with two semi-elliptical incisions, embracing the nevus and including a good portion of the normal skin on all sides, extended so as to meet at their extremities. The section is then grasped with an Allis forcep at one angle and by sharp dissection, the wedge of tissue is removed in toto, including some of the normal underlying fat. (This is preserved for biopsy by the pathologist.) Trial coaptation of the wound edges will indicate if underscoring is required. The wound is closed with three or four simple sutures of .000 dermal.

A simple procedure has been described for the excision of moles. A large percentage of these lesions, when present on the foot, may be pre-cancerous. It is recommended that the chiropodist surgically excise these nevi as a routine prophylactic measure. Failure to recognize this potential danger is a dereliction of the practitioner's responsibility to his patient.

614 Newark Avenue

References

1. Ferguson, L. K., M.D.: *Surgery of the Ambulatory Patient*, J. B. Lippincott, Philadelphia, Pa., pp. 199-201, 1955.
2. Lewin, P., M.D.: *The Foot and Ankle*, Lea & Febiger, Philadelphia, Pa., 1940.
3. Tobias, N., M.D.: *Essentials of Dermatology*, J. B. Lippincott, Philadelphia, Pa., 1948.
4. Towers, R. P.: *Diagnostic Criteria of Malignant Melanoma of the Skin*, J.A.P.A., Vol. 48, No 2, pp. 96, February 1958.

For years and years I had to make a lengthy explanation
Whene'er, upon the questionnaire, it read, "Your Father's occupation."
Though not a part of what had been my formal education
I soon prepared a little "squib" for prompt dissemination.
It really didn't help too much for when I was all through,
The words I wrote, I soon found out, had only reached a few.
The others scratched their shiny pates, their faces blue in hue,
And then the questions popped out fast, as if they'd come on cue.
The P. A. Dutch with garbled tongue give all our words a twist.
They trot to KWI-RO-PRACTORS, so hence KWI-ROP-O-DIST.
But others bellowed, "Not so fast, the accent has been missed,
To say it right you must speak soft. One says SHEER-ROP-O-DIST."
All's different and the N.A.C. is now the A.P.A.,
And to the questionnaires that come, I'll stand right up and say,
"PODIATRIST'S the proper name, but if you're stuck you may
Try using old "Foot Specialist"; your money's still O. K.

Many State Departments of Education have mailed to all guidance personnel in their states, copies of an occupational monograph on a particular profession. This service was given without charge. All the profession had to do was supply quantities of the monograph.

Why not write to your State Department of Education, enclosing a copy of CHIROPODY AS A CAREER, and request that they send them to guidance personnel in your state? Better still, go to see them personally.

The fact that the State Department sends out CHIROPODY AS A CAREER lends prestige to our profession. Why not contact them?

JOURNAL
OF THE
AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

PUBLISHED UNDER THE DIRECTION OF THE EXECUTIVE COUNCIL BY THE AMERICAN PODIATRY ASSOCIATION

3301 Sixteenth Street, N.W., Washington 10, D. C.

A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

PRESIDENT MORRIS' MESSAGE

We all join in welcoming the words of America's most distinguished citizen, President Dwight D. Eisenhower. It is an eloquent commentary on the beneficence of our democracy when its First Citizen and Chief Executive utilizes the prestige of his high office to stimulate and foster the physical and emotional health of the nation in general and of our youth in particular. Hence, it gives me a great deal of pleasure as President of the American Podiatry Association to congratulate those of our committee chairmen who arranged our very significant participation in this youth fitness program. Podiatry-chiropody has, of course, long been concerned with the foot health of the nation and much of its research and development has been devoted to both the congenital and acquired defects encountered in the treatment of children.

Dr. Shane MacCarthy's statement is an admonition to all of us that podiatry-chiropody must play a significant role in the development of youth fitness.

We, the members of the American Podiatry Association, who are the custodians of the foot health of the nation, willingly accept the responsibilities and challenges incidental to the implementation of this program. We recognize that a tremendous amount of further research will be required. We are altogether confident that with adequate development of our teaching institutions, research will be the logical sequence that will contribute much to the youth fitness program.

With our annual meeting only two months away, special commendation due the team preparing for this event. They are, indeed, highly synchronized, highly organized and, to every conceivable appearance, highly efficient. This summer promises to be the prelude to a whole new era of great annual meetings. Never, in this writer's experience, has he witnessed scientific, social and cultural programs so carefully calculated to meet our professional needs and desires as does this one. You will agree that it will be both stimulating and enlightening. The enthusiasm of the committee seems to have communicated itself throughout the country. Your president, in his many travels throughout the nation these last several weeks, has been delighted to encounter this enthusiasm in great abundance.

Serve public health and serve yourself by keeping your date in '58!

JONAS C. MORRIS, D.S.C.

The PRESIDENT
of
UNITED STATES of AMERICA

"Our national policies will be no more than words if our people are not healthy of body, as well as of mind.

"Our young people—our most precious asset—must be physically as well as mentally and spiritually prepared for American citizenship.

"There is a need for arousing in the American people a new awareness of the importance of physical and recreational activity that our young people may achieve a proper balance of physical, mental, emotional, and spiritual strength."

—June 19, 1956
DWIGHT D. EISENHOWER

By appointing a National Committee on Youth Fitness and proclaiming Youth Fitness as the theme for our annual meeting, as announced in the May issue of the *Journal*, we have evidenced our desire to cooperate with the President's Council on Youth Fitness, an especial interest of his. To stimulate the interest of all our members, the White House provided the *Journal* with the photograph and suggested the excerpts from Presidential statements quoted above.

OUR NEWEST MEMBERS OF THE PROFESSION

EACH YEAR at this season we welcome into the profession another group of earnest individuals who have dedicated themselves to a life of service to help allay at least a small portion of mankind's suffering.

The people of our schools have discharged a great responsibility in a competent, diligent and dedicated manner by preparing the graduates for their life's work. To their shoulders now falls the responsibility of fulfilling in a similar manner the charge given them. We know this will be accomplished.

The concern of all graduates upon acceptance into full professional life is to achieve a niche for themselves as individuals. Society exacts a greater obligation from professional peoples than this. Only a few in our great Nation have the opportunity, the inclination, the ability, the diligence and even the financial wherewithal to achieve a professional education. These few people must provide leadership in all facets of our society. They are not only expected to, but they must exercise this God-given opportunity and duty in their neighborhoods, local communities, professional, social, service and religious organizations and at any place or level at which they are asked and can serve; and if not asked to serve, must offer to serve.

To the graduating students who have been so carefully prepared for professional life, we extend our best wishes, fondest hopes and greatest expectations. We know they will discharge the great task of ministering our foot suffering public and will accept the wider vista of complete professional responsibility.

ADDITIONAL PROPOSED AMENDMENT TO THE CONSTITUTION AND BYLAWS

PROPOSITION Y

The following proposed amendment to the Constitution and Bylaws was received at the national office May 2, 1958. This is more than ninety days prior to the annual meeting but it did not arrive in time to be included in the May issue of the Journal so that it could be published in the May issue and it is therefore being noticed in the June issue.

WHEREAS, the present arrangement of the Executive Council does not represent a fair and proportionate territorial distribution; and

WHEREAS, a more equal representation was the desire of the makers of the original change to our Constitution and Bylaws; and

WHEREAS, a more ideal representation could be possible through a Council consisting of the elected officers and one representative from each region; therefore

BE IT RESOLVED, the following changes be submitted to the House of Delegates for the Annual Session in Washington, D. C., in August 1958

All Sections of Article V of the national Constitution and Chapter IV of the Bylaws of the original *Constitution and Bylaws (adopted 1919) and since amended and changed up to the present date,* be hereby dissolved and replaced as follows:

Article V—Constitution

1. The Executive Council, as an executive body, shall be composed of the elected officers and one member from each of the twelve (12) regions. The retiring President of the Association shall be a member of this Council for one year after his term as President expires. This Council shall act as a finance

committee of this Association and shall have such powers and duties as the Bylaws may prescribe, or as are definitely delegated to the Council by a House of Delegates. The Council may adopt rules and regulations for its own government and for the affairs of the Association within its control. It shall not act in any manner repugnant to the Constitution and Bylaws of this Association or to the rules which may be adopted by a House of Delegates.

2. Each region after the passage of this amendment will elect within ninety (90) days, a representative to the Executive Council. In the interim, the elected officers will act as the Executive Council. In order that one half (½) of this Council is carried over each year, Regions One (1), Three (3), Five (5), Seven (7), Nine (9), and Eleven (11) will elect their representatives for a term of one (1) year (the initial year). Regions Two (2), Four (4), Six (6), Eight (8), Ten (10) and Twelve (12) will elect for a period of two (2) years. Thereafter all regions will elect their representatives for a two (2) year basis.

Chapter IV of the Bylaws

1. The Council shall meet immediately before and after the close of the annual meeting to organize for the coming year. The Council shall meet at such times as occasion may demand, either upon the call of the President or upon the request in writing of the majority of the members constituting the Council.
2. The Council shall have the power to approve any contracts entered into by the business manager of the Journal on behalf of the Association. The Council shall have the power to provide for and superintend all publications and their distributions. The Council shall audit annually the accounts of the Secretary and the Business Manager of the Journal and present a statement of same in its annual report to the House of Delegates. The Council shall specify the cost, profit or loss and character of all publications and the amount of all property belonging to the Association. The Council shall have the supervision of all arrangements of the annual meeting.

Submitted by
Arkansas State Chiropody Society

YOUTH FITNESS COMMITTEE

President Morris has appointed Dr. Seward P. Nyman of Washington, D. C., and Dr. Burdette L. Anderson of Fairview Park, Ohio, as Co-chairmen of a National Committee on Youth Fitness, to cooperate with Dr. Shane MacCarthy, Executive Director of President Eisenhower's Council on Youth Fitness. Also serving on the committee are Dr. John T. Sharp, Abington, Pa.; Dr. H. V. Levin, Norristown, Pa.; Dr. Stanley Hilbronner, Camden, N. J.; Dr. Melvin Stuker, Savannah, Ga.; Dr. R. M. Kingland, Boise, Idaho, and Dr. Morris Haas, Albuquerque, N. Mex.

WASHINGTON REPORT

CONGRESS CONSIDERS:

Medicare

The House Appropriations Committee opened a special inquiry on the Medicare program of the Defense Department. It is believed that the program is in for several changes, especially in the privilege which military dependents have in their choice of either private or federal care. Medicare has requested 80 million dollars for the next fiscal year; the costs being charged to the government have caused considerable comment on the bill.

It was hoped that Medicare would serve as an incentive for re-enlistments but this has not been shown in present service figures. Costs of a patient in a private hospital and physician's care come to about $50.00 per day, whereas similar care in a government hospital is only about $26.00 per day. It is estimated that at least 5 million dollars more will be needed to cover the present fiscal year. The subcommittee has been critical of the Department of Defense policy of allowing military dependents to choose either civilian or military doctors and hospitals for medical services.

House Commerce Committee

Hearings were held by the Health & Science Subcommittee on House Bills 6874, 6875 and 7841, which provide federal subsidies to promote construction of medical and dental research and teaching facilities. Besides the American Podiatry Association, representatives of the American Veterinary Medical Association, and American Nurses Association voiced their objection that the bills only provide for schools of medicine, osteopathy, dentistry, and public health and ignore the needs of podiatry, veterinary and nursing. Dr. Abe Rubin represented the American Podiatry Association.

These bills were supported by all organizations, some with reservations. However, educators agree that such assistance is imperative.

Veterans Administration

Dr. William S. Middleton, Chief Medical Director of Veterans Administration, has signed a new directive (Circular 10-51), which sets up a new procedure of negotiating "home town care" fee schedule. It authorizes the chief medical officers in each state "to consummate agreements with professional associations, private and public organizations, or persons to provide essential medical and ancillary services of acceptable professional standards on a fee basis in behalf of eligible veterans under conditions specifically approved by the Chief Medical Director."

State Associations of the American Podiatry Association are advised to contact their local Medical Director of Veterans Administration and negotiate fee schedules pursuant to Circular 10-51.

Public Health Services

Those members of the APA who are interested in medical prepayment plans can receive free, a copy of "Digest of Prepaid Dental Care Plans 1958," which was just published as a 41-page directory by the U. S. P.H.S. and includes all the known prepaid plans now in use in this country. Those interested in Industrial Podiatry-Chiropody can obtain some ideas as the booklet covers union sponsorship as well as employer-employee sponsorship. Single copies may be obtained upon request from the Division of Dental Resources, Public Health Service, Washington 25, D. C.

WE HAVE A DATE IN '58

RAYMOND K. LOCKE, D.S.C.
Chairman, Convention Executive Council Subcommittee

As Chairman of the A.P.A. Convention Committee, I take this opportunity to give you this message about the 1958 A.P.A. Convention to be held at the Hotel Shoreham, Washington, D. C., August 22-26.

From present plans this promises to be the greatest meeting in the history of our profession. The hotel we have selected is one of the most beautiful hostelries in the U. S. It is situated on the edge of lovely Rock Creek Park, is completely air-conditioned and offers decor and food hard to be surpassed anywhere.

The selection of our Nation's Capital as the scene of our '58 meeting will afford everyone an opportunity of sightseeing rarely before available. Every effort has been made by the Local Arrangements Committee, under the very able chairmanship of Dr. Charles Turchin, to provide a program for every member of every family —for this will be a family convention. Free tours for all those registered at the hotel (a nominal charge to others), golf tournaments for the "pros and the duffers," a zoo near the hotel for the children, a "coketail" party for the teen-agers (with their own registration and reception center), a magnificent outdoor banquet in the shadow of the fabulous Shoreham fountain, wonderful dancing and the pleasure of witnessing the burning of our headquarters building mortgage.

The scientific program has been tailored to the needs, requests and expectations of the profession. This has been based on questionnaires filled out at the 1957 convention by those present and also after many meetings, consultations and thinking by the committee. The program will consist of short lectures and longer, more extensive workshops. Almost every facet of practice will be covered, for example, clinical photography in novice, intermediate and advanced workshop sections. Many workshops are being repeated so that if missed one time they may be picked up another. Four outstanding features for lecture and panel presentation have been scheduled. These feature nationally known figures and authorities in their fields. Among these are Admiral Ross T. McIntyre, former Surgeon General of the Navy and now Executive Director of the International College of Surgeons and Richard T. Smith, M.D., Director, Department of Rheumatology, Benjamin Franklin Clinic of the Pennsylvania Hospital and Harry Ronald Fishman, one of the outstanding authorities on foot rehabilitation through resistance remedial exercises. This last will create tremendous interest in a new field, barely tapped by our profession and offering new concepts of practice.

One of the outstanding features of the last national convention was the scientific exhibits. This year this feature has been expanded. A much larger, separate area has been provided to house the scientific exhibits. In order to induce greater participation, gold, silver and bronze medals will be awarded the best exhibits. The medals and awards will be named for the various deceased deans and presidents of our colleges. The Scientific Exhibits this year will be outstanding and provide excellent informative and educational material. The Air Force, Veterans Administration, Army, Navy and the Mayo Clinic will also have extremely interesting informative exhibits. The popular motion picture science theater will run continuously Sunday, Monday and Tuesday.

But here is still one more great feature—the Armed Forces Institute of Pathology will televise for two hours on Monday,

August 25th, and Tuesday, August 26th, in live theatre-style COLOR TELEVISION from the Walter Reed Hospital. Features such as 1. Corrective Nail Surgery (one or more of the following techniques) (a) Winograd, (b) Frost, (c) Plastic Lip, (d) Nail Plate Elevation and/or Avulsion, (e) Negative Galvanic Nail Correction; 2. Acrylic Nail Techniques; 3. Needle Positioning for Intra-articular Paracentesis; 4. Polyvinyl and other Resilient Plastic Materials for Crest Molds; 5. Sutures and Suture Knots; 6. Use of Vitamin A preparations for Sub- and Intra-lesion Injection for Helomata and Resistant Plantar Verruca will be shown. It is worth attending for this feature alone.

The theme of the 1958 meeting will be "Youth Fitness." This is in line with President Eisenhower's program on youth fitness for 1958. Accordingly, Dr. Shane MacCarthy, Executive Director of the President's Council on Youth Fitness, will be one of our feature speakers. Dr. MacCarthy has extended the full cooperation of this Council to help the A.P.A. get American youth "off its seat and on its feet" again.

Much will be heard on the convention with each issue of the JOURNAL.

Remember, "we have a date in '58."

TENTATIVE SCIENTIFIC PROGRAM
1958 Annual Meeting

SATURDAY

10:45 A.M.	Movie	Palladian Room
11:00-11:30 A.M.	Parasthesias of the Foot Marvin Steinberg, Pod.D. Lecture	Palladian Room
11:00-12:00 Noon	Workshop in Manipulative Technics R. B. Nicklas, D.S.C. and H. L. Collins, D.S.C.	West Ballroom
11:30-12:00 Noon	Care of Office Emergencies Harry L. Hoffman, Ph.G., D.S.C. Lecture	Palladian Room
12:00- 1:30 P.M.	LUNCHEON—VISIT EXHIBITORS	
1:30- 2:00 P.M.	Parasthesias of the Foot Marvin Steinberg, Pod.D. Illustrations, Demonstrations	Palladian Room
1:30- 2:00 P.M.	Care of Office Emergencies Harry L. Hoffman, Ph.G., D.S.C. Demonstrations Morton Wittenberg, D.S.C.	West Ballroom
2:00- 3:00 P.M.	Communications in Medicine: On Writing J. P. Gray, M.D.	Palladian Room
3:00- 3:30 P.M.	Time to Visit Exhibitors	
*3:30- 5:30 P.M.	Podopediatric Symposium John T. Sharp, D.S.C., Louis Burger, D.S.C. and others, Lectures and demonstrations	Palladian Room
3:30- 4:00 P.M.	Impact Dispersion, Diffusion and Absorption in Hyperkeratosis Emanuel Frankel, Pod.D.	West Ballroom
4:00- 4:30 P.M.	Musculo-Skeletal Tension Syndrome. The Podiometer-Diagnostic Weight Distribution.	West Ballroom

	W. A. Pepin, D.S.C. Lecture	
4:30- 5:30 P.M.	Pepin—Demonstration and Workshop	Foyer B
	SUNDAY	
9:00- 9:30 A.M.	Movie	Palladian and West Ballroom
9:30-10:30 A.M.	Ten Common Dermatoses Seen in Podiatry William Ignatoff, D.S.C. and Samuel Brezak, Pod.D. Illustrated Lecture	Palladian Room
9:30-10:30 A.M.	Casting Techniques Paul Schneyer, D.S.C., Sidney Sivitz, D.S.C. and others Demonstrations and Workshop	West Ballroom
10:30-11:00 A.M.	VISIT OUR EXHIBITORS	
*11:00-12:00 Noon	Remedial Exercises Program for Postural Rehabilitation in your Practice Harry R. Fishman, B.S.M.S. Illustrated Lecture	Palladian Room
12:00- 1:30 P.M.	LUNCHEON, VISIT EXHIBITORS	
*1:30- 2:30 P.M.	Rehabilitation of Foot Conditions Demonstration and Workshop	Foyer B
1:30- 2:00 P.M.	Medical Hypnosis Harold W. Lindy, D.S.C., Jack Sanders, D.S.C.	Palladian Room
2:00- 3:00 P.M.	Casting Techniques Workshop (repeat)	West Ballroom
2:00- 3:00 P.M.	Medical Hypnosis Demonstration and Workshop	Palladian Room
3:00- 3:30 P.M.	VISIT EXHIBITORS	
3:30- 4:00 P.M.	Dermatology Workshop William Ignatoff, D.S.C., Samuel Brezak, Pod.D.	West Ballroom
3:30- 4:30 P.M.	American Society of Chiropodical Roentgenologists	Palladian Room
4:30- 5:30 P.M.	American College of Foot Orthopedists	Palladian Room
	MONDAY	
9:00-10:00 A.M.	Color T.V.	Terrace Banquet Room
10:00-10:30 A.M.	The Modern Place for the Podiatrist in Relation to the Medicine of Today and the Future Ross T. McIntyre, M.D.	Terrace Banquet Room
10:30-11:00 A.M.	VISIT EXHIBITORS	
11:00-12:00 Noon	American College of Foot Surgeons	West Ballroom
*11:00-12:00 Noon	Rehabilitation of Foot Conditions Harry R. Fishman, B.S., M.S. Workshop	Foyer B
12:00- 1:30 P.M.	LUNCHEON, VISIT EXHIBITORS	

1:30- 2:00 P.M.	Shoes, the Shoe Industry and the Podiatrist William A. Rossi, D.S.C., Field Editor, *Boot and Shoe Recorder*	West Ballroom
1:30- 2:00 P.M.	Needle Positioning G. Elmer Harford, D.S.C. Workshop	Palladian Room
*2:00- 2:30 P.M.	Fitness in Living Dr. Shane MacCarthy, Executive Director President Eisenhower's Council on Youth Fitness	West Ballroom
2:30- 3:00 P.M.	VISIT EXHIBITORS	
3:00- 5:00 P.M.	Symposium on Rheumatic Diseases Richard T. Smith, M.D. Eugene Lipow, M.D. Louis P. Zulli, D.S.C. Raymond K. Locke, D.S.C.	West Ballroom
4:30- 5:00 P.M.	Needle Positioning Workshop G. Elmer Harford, D.S.C. (cont.)	Palladian Room

TUESDAY

9:00-10:00 A.M.	Color T.V.	Terrace Banquet Room
10:00-10:30 A.M.	Podopediatric Workshop	Palladian Room
10:00-10:30 A.M.	Clinical Photography Martin Blass, Pod.D. Lecture and Slides	West Ballroom
10:30-11:00 A.M.	VISIT EXHIBITORS	
11:00-12:00 Noon	Clinical Photography Workshop Martin Blass, Pod.D., Rosemary Becker, D.S.C., Joseph Nemiroff, Pod.D. Novice, Intermediate and Advanced Section Workshops	West Ballroom
11:00-12:00 Noon	Forefoot Balance Workshop Drs. Cope, Kagle, Sutker, Moskow	Palladian Room
12:00- 1:00 P.M.	LUNCHEON, VISIT EXHIBITORS	
1:00- 1:30 P.M.	Survey and Evaluation of Veterans Administration Podiatry Staffing Program Martin Mussman, Pod.D.	West Ballroom
1:00- 1:30 P.M.	The Physiology of Pain James Meade, D.S.C.	Palladian Room
1:30- 2:00 P.M.	American Association of Hospital Chiropodists	West Ballroom

2:00- 2:30 P.M.	LAST CHANCE TO VISIT EXHIBITORS	
3:00- 4:00 P.M.	A.C.F.O.	Palladian Room
3:00- 4:00 P.M.	A.C.F.S.	West Ballroom
4:00- 5:00 P.M.	A.S.C.R.	West Ballroom
4:00- 5:00 P.M.	Needle Positioning G. Elmer Harford, D.S.C.	Palladian Room

Asterisk items denote features of Youth Fitness theme.

25 papers submitted for the Stickel and Drew Research Awards

Hall of Science
7 hours of continuous new sound movies repeated daily
30 Scientific Exhibits

ADVANCE REGISTRATION FOR ANNUAL MEETING

So you won't have to wait around at a registration desk, we have provided in this issue (1) a postage prepaid return postcard upon which you may make direct reservations at the hotel for your requirements, (2) convention registration card which can be torn out and placed in an envelope addressed to the National office, accompanied with your check.

When you arrive at the meeting, all you have to do is go to the advance registration desk and pick up an envelope containing your badges, banquet tickets, registration cards, program booklets, pamphlets describing the attractions in Washington and all necessary material. **Money will be refunded to advance registrants who do not attend the meeting.**

Examine the convention program carefully on pages 266-267 and note the many scientific, technical and social attractions.

Golf duffers and/or champions are invited to enter the National Golf Tournament. See below.

GOLF TOURNAMENT

WHAT we expect will be an annual affair is the National Golf Tournament of the American Podiatry Association. The tournament will take place on Friday, August 22nd, 1958 and Monday, August 25th, 1958, at the Rock Creek Golf Club, not more than ten minutes from the Shoreham Hotel.

It is not necessary to have a club or state handicap to play in this tournament. The final net scores will be determined via the Calloway Handicap System. The highest score recorded may win a trophy via the Calloway Handicap System. All decisions rendered by the Golf Committee are final. The committee will be responsible to you and will arrange everything for your golfing pleasure.

The American Podiatry Association will take pleasure in presenting the first National Champion Golf Trophy. The July issue will have an illustration of the trophy. Other prizes include trophies for the following divisions: 1st, 2nd and 3rd Gross and 1st, 2nd and 3rd Net. Woman's Division, 1st Gross and 1st Net. The entry fee of $5.00 includes greens fees for one round and caddy cart.

If you have any questions about the tournament, contact Dr. Martin Mintzer, Golf Tournament Committee Secretary, 13A Mississippi Ave., Washington, D. C.

REPORT OF COUNCIL ON EDUCATION
AMERICAN PODIATRY ASSOCIATION

August, 1957 **Chicago, Illinois**

THIRTY-EIGHTH ANNUAL REPORT

Mr. President and members of the House of Delegates. Herewith is submitted the 38th annual report of the activities of the Council on Education during the course of the year, and of the deliberations here in Chicago the last four days.

For the first time in the history of the Council on Education, we were honored with the presence of Dr. Harold Goldthorpe, accreditation specialist of the Division of Higher Education of the United States Office of Education of the Department of Health, Education and Welfare. Dr. Goldthorpe participated in the deliberations of the Council during the first day of our meeting as an unofficial observer to familiarize himself with the conduct of the Council on Education.

It was also our privilege to have with us during most of our deliberations Dr. Joseph Lawrence, medical consultant to the National Association of Chiropodists.

The problems which presented themselves to the Council on Education during the course of the year were, as usual, many and varied. Because of the very fine organization developed, each problem was assigned to the specific subcommittee charged with that responsibility, and in nearly every case a satisfactory result was obtained.

The Council adopted a method whereby each member of the Council received periodically a complete resume of all correspondence directed to the Council. All Council members were kept adequately informed of the many problems necessitating Council action. Copies of these monthly reports were also sent to your president and president-elect.

POLICY

The Council finds itself gradually emerging from an era when it was necessary to police our educational institutions, to a new era where more emphasis is being placed on leading and guiding these institutions. This has developed because we find that our schools are more receptive to the recommendations of the Council on Education, and we believe that this attitude is partially due to the fact that representatives of the schools are now participating in the development of Policy.

However, the development of Policy is a long range program and has many facets. We feel that we have made substantial progress in this field and hope that within the very near future we may have completed our program.

EDUCATIONAL STANDARDS

At long last our subcommittee on Curriculum has developed what, in our opinion, is a standard for all schools to adopt. This has been submitted to the deans of all schools who will meet in the very near future with our subcommittee for final approval.

The Council recommends at this time that the two and four requirement shall be inaugurated not later than 1960 by those schools which are not now operating on that basis.

EDUCATIONAL PROBLEMS

One of the serious problems confronting our schools at this time is the low enrollment of students in an era when many colleges and universities are finding it necessary to turn away large numbers of applicants for lack of adequate facilities. This, in part, is due to the fact that neither

the schools nor the profession at large have been willing or able to assume their share of responsibility in the recruitment of prospective students. As a result of this situation, nearly all of our schools operated at a deficit last year, which has resulted in a depletion of financial resources.

The one exception to this situation is the California College of Chiropody, which not only presented a substantial surplus of income over expenditures, but also made a major investment in new equipment, and as a result of this sound program, the prospects are very bright for a full enrollment for the next freshman class.

SCHOOLS

Some of the events which we wish to report concerning our schools are as follows:

Temple School of Chiropody: The biennial inspection of the Temple School of Chiropody this year was delayed so that it could be made at the same time as an evaluation of the University by the Middle Atlantic States Association of Colleges and Secondary Schools. This is the first time that our accrediting agency has had the privilege of participating with an evaluating agency of such stature. We believe that this epoch-making experience resulted in the appointment of Dr. Charles E. Krausz as a full-time dean of the Chiropody School as of July 1st, and the definite prospects of moving to new and better quarters in a building located in the campus area of Temple University.

New York College: Due to the passing of Dr. M. J. Lewi, president of the New York College of Podiatry, changes have taken place at the college. Dr. Lewi was the father of scientific chiropody, first honorary member of the National Association, and recipient of many honors from the colleges and organizations of our profession.

At a recent meeting of the Board of Trustees, Dr. Herman Sonderling was elevated to the office of president and dean of the school as of July 1st.

The New York College is now operating under a provisional charter, and they have informed us that a drive for funds, by a professional fund-raising agency, will start September 1, 1958, to provide the necessary assets required by law to obtain a permanent charter as an independent school.

Ohio College: It has been reported by the representatives of the Ohio College of Chiropody that the school has developed a five-year plan in cooperation with the Alumni Association of the college, which will include new buildings and major faculty improvements.

Chicago College: The Board of Trustees of the Chicago College of Chiropody at a recent meeting elected two new members to fill vacancies on the Board and has appointed a new dean, assistant dean, and registrar to administer the affairs of the college. The Board of Trustees also advised us that they contemplate changes in and additions to the faculty. Due to these changes, the Council on Education feels that it may be necessary to lend immediate assistance and guidance, and to continue this activity during the coming year.

During the past year, none of our Chiropody colleges participated in a post graduate course for the granting of either certificates or diplomas.

This is the year in which the biennial school inspections will be made.

RESUME OF SUBCOMMITTEES OF THE COUNCIL ON EDUCATION

POLICY COMMITTEE: The Policy committee of the Council on Education attended a meeting at the request of the Executive Council, which was held in Washington, D. C., January 25th and 26th in conjunction with a meeting of the Executive Council and representatives from the United States Department of Health, Education

and Welfare, and representatives from the United States Public Health Service.

CLINICS COMMITTEE: The Clinics committee is engaged, as usual, in gathering statistical information with regards to the operation of the clinics in our various colleges.

FINANCIAL COMMITTEE: It is regrettable that after the examination of the financial reports of our chiropody colleges, we find that four of them suffered sizeable losses. One of the schools operated within a balanced budget and the other showed a financial gain.

TRANSFERS COMMITTEE: The Transfers committee reported that it received and processed 13 requests for transfer or evaluation of credentials. There has been a marked increase in requests from foreign students and practitioners for evaluation of their credentials in the hope of being allowed to practice in the United States. We have also received a number of requests from State Boards asking for evaluation of credits submitted for licensures by graduates and practitioners in foreign countries.

ADMINISTRATIVE POLICY: Only one important change was made in the administrative policy of the Council on Education, which was to amend the minimum entrance requirements, Article II, Section 1, by the addition of the words "in an accredited college" in the proper place.

CURRICULUM COMMITTEE: The chief concern of the Curriculum committee in the future will be to help coordinate and implement the proposed curriculum when and if inaugurated by the colleges.

HOSPITAL ACCREDITATION COMMITTEE: The Council on Education has created a committee for Hospital Accreditation, to inspect and evaluate those hospital institutions operated by chiropodists.

REPORT OF STATE BOARD EXAMINATION RESULTS*

The Secretary of the Council on Education, as in previous years, collected certain statistical information concerning the results of examination of candidates for licensure in 48 states, the District of Columbia, and Hawaii. Replies to this request were received from 38 states, the District of Columbia and Hawaii.

The total number of candidates examined was 194, consisting of 190 males and 4 females. Of this number 174 males and 2 females passed, and 16 males and 1 female failed.

The *New York College of Podiatry* supplied the greatest number of candidates, namely 65 who took examinations in six states and the District of Columbia. Sixty-three males and one female passed; one male failed. The State of New York examined 48 candidates, 47 males and one female. Forty-six were graduates of the New York College, as well as one male candidate from the Temple University College of Chiropody, and one female from the Ohio College of Chiropody. Both of the latter failed.

Temple School of Chiropody had the second highest number of candidates, namely, 40, who were examined in 12 states. Of this number, 35 males and 1 female passed, while 3 males and 1 female failed.

Illinois College, with 23 candidates examined in 11 states, 22 males passed and 1 female failed.

Twenty-one candidates from the *Ohio College of Chiropody* were examined in

* (Note: Following the 1957 Annual Meeting of the Council on Education, at which the foregoing 38th Annual Report was read to the House of Delegates, the Council on Education obtained additional information from nine of the States whose results on state board examinations were missing at the time of the Report. These results have been added to the tabulations presented at that time and are included in the Tables and Reports appended to this report and are made a part of same.)

State Board Reports—1955

Margin Number		Total Number Examinations		California College of Chiropody				Chicago College of Chiropody				College of Podiatry Long Island University				Illinois College of Chiropody				Ohio College of Chiropody				School of Chiropody Temple University				Non-Accredited Schools				Margin Number
		M	F	M		F		M		F		M		F		M		F		M		F		M		F		M		F		
				P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	
● 1	Alabama	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1
2	Arizona	1	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	2
3	Arkansas	1	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	3
4	California	2	..	1	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	4
● 5	Colorado	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	5
6	Connecticut	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	6
7	Delaware	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	7
8	Dist. of Columbia	6	..	..	..	..	..	..	..	..	..	2	..	..	..	..	1	..	..	2	..	..	..	1	..	..	..	..	..	..	..	8
▲ 9	Florida	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	9
10	Georgia	2	..	1	..	..	..	..	..	..	..	..	..	..	..	2	..	..	..	..	..	..	..	1	1	..	..	..	..	..	..	10
11	Idaho	3	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	11
12	Illinois	50	1	..	..	..	..	8	1	1	..	..	..	..	..	22	..	..	..	..	..	..	..	..	..	..	*	8	11	..	..	12
13	Indiana	9	2	..	..	..	..	4	..	..	..	1	0	1	..	3	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..	13
14	Iowa	3	..	..	..	..	..	..	..	..	..	..	..	..	..	3	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	14
15	Kansas	1	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	15
16	Kentucky	3	..	..	..	..	..	1	1	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	16
● 17	Louisiana	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	17
18	Maine	2	..	..	..	..	..	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	18
19	Maryland	2	..	..	..	..	..	..	..	..	..	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	19
20	Massachusetts	10	..	..	..	..	..	..	..	..	..	1	..	..	..	1	..	..	..	..	..	..	..	..	..	..	**	8	..	..	..	20
21	Michigan	22	..	..	..	..	..	1	..	..	..	1	..	..	..	6	3	..	..	7	2	..	..	2	..	..	..	..	..	..	..	21
22	Minnesota	2	..	..	..	..	..	..	..	..	..	..	..	..	..	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	22
● 23	Mississippi	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	b	..	..	..	23
24	Missouri	1	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	24
▲ 25	Montana	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	25
26	Nebraska	1	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	26
27	Nevada	1	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	27
● 28	New Hampshire	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	28
29	New Jersey	8	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	2	..	..	..	5	..	..	..	b	..	..	..	29
30	New Mexico	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	b	..	..	..	30
31	New York	36	1	..	..	..	..	..	1	..	..	32	2	1	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	31
32	North Carolina	5	..	..	..	..	..	..	1	..	..	..	2	..	..	..	..	..	..	1	1	..	..	..	..	..	..	..	..	..	..	32
▲ 33	North Dakota	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	33
34	Ohio	34	..	..	..	..	..	2	..	..	..	..	..	..	..	4	..	..	..	26	2	..	..	..	..	..	..	..	..	..	..	34
● 35	Oklahoma	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	35
● 36	Oregon	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	36
37	Pennsylvania	34	3	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	5	..	1	1	27	1	1	..	..	..	..	..	37
38	Rhode Island	6	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	5	..	..	..	..	..	..	..	38
● 39	South Carolina	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	39
● 40	South Dakota	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	40
41	Tennessee	2	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	41
42	Texas	10	..	..	..	..	..	3	..	..	..	..	..	..	..	2	..	..	..	4	1	..	..	..	..	..	..	..	..	..	..	42
● 43	Utah	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	43
● 44	Vermont	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	44
45	Virginia	3	..	..	..	..	..	..	..	..	..	1	..	..	..	..	1	..	..	1	..	..	..	..	..	..	..	a	..	..	..	45
● 46	Washington	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	46
47	West Virginia	5	..	..	..	..	..	..	..	..	..	..	..	..	..	3	..	..	..	2	..	..	..	..	..	..	..	..	..	..	..	47
48	Wisconsin	7	..	..	..	..	..	1	..	..	..	..	..	..	..	6	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	48
49	Wyoming	2	..	..	..	..	..	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	a	..	..	..	49
● 50	Hawaii	0	0	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	50
	TOTALS	276	7	3	..	..	..	25	4	1	..	42	4	2	..	62	5	1	..	53	7	1	1	42	2	1	..	..	..	..	..	

▲ No information furnished

* Northwestern Institute

1955 Record of Schools in State Board Examinations*

	Number of States Covered	Total Number of Examinations	Results Male P	Male F	Female F	Female P	Per Cent Failed
California College of Chiropody	3	3	3	—	—	—	0.0
Chicago College of Chiropody	10	30	25	4	1	—	13.3
New York College of Podiatry	9	48	42	4	2	—	8.3
Illinois College of Chiropody	19	68	62	5	1	—	7.3
Ohio College of Chiropody	12	62	53	7	1	1	11.3
Temple University School of Chiropody	7	45	42	2	1	—	4.4
Northwestern Institute**	1	19	8	11	—	—	57.9
Massachusetts School of Chiropody**	1	8	8	—	—	—	0.0
Totals		283	243	33	6	1	

(*) Based on reports from 45 States, District of Columbia and Hawaii.
(**) Non-accredited schools.

1956 Record of Schools in State Board Examinations*

	Number of States Covered	Total Number of Examinations	Results Male P	Male F	Female P	Female F	Per Cent Failed
California College of Chiropody	3	10	9	1	—	—	10.0
Chicago College of Chiropody	11	25	21	4	—	—	16.0
New York College of Podiatry	7	65	63	1	1	—	1.54
Illinois College of Chiropody	20	50	47	2	1	—	4.0
Ohio College of Chiropody	18	53	43	7	2	1	15.1
Temple University School of Chiropody	16	51	45	4	1	1	9.8
Massachusetts School of Chiropody**	1	8	8	—	—	—	0.0
Northwestern Institute**	1	5	—	5	—	—	100.0
Totals		267	236	24	5	2	

(*) Based on returns from 47 States, District of Columbia and Hawaii.
(**) Non-accredited schools.

14 states with the result that 18 males passed, 2 males and 1 female failed.

The *Chicago College of Chiropody* had 20 candidates who took examinations in 7 states. 17 males passed and 3 failed.

The lowest number of graduates who were candidates for licensing examination came from the *California College of Chiropody*, and were examined in 3 states. Nine males passed and one male failed.

Among the graduates of the two non-accredited schools, 8 males from Northwestern Institute of Chiropody took the licensing examination in the State of Illinois and all passed.

Massachusetts School of Chiropody had 5 graduates, all males, taking the Massachusetts examination. All failed.

The State of California had the highest number of candidates ever to present themselves for licensing examination in that state, namely, 32. Graduates from all of our schools, all passed.

The following states have not as yet submitted their statistics: Florida, Iowa, Louisiana, Michigan, Minnesota, New Jersey, North Dakota, Ohio, Texas and Utah. Ten states had no candidates and 5 states issued 6 licenses by reciprocity.

GENERAL: The Council, as usual, received many requests from prospective students for information concerning the various schools and other pertinent material. These were handled as expeditiously as possible. Two years ago, a recommendation, which received approval, called for a transcript of each applicant's pre-chiropody training. This was done to improve our records and

REGISTRATION 46th ANNUAL MEETING

American Podiatry Association

(Please print or type)

NAME _____

ADDRESS _____

CITY _____ STATE _____

- ☐ Member **$20.00**
- ☐ Wife—Guest (For additional banquet ticket) **10.00**
- ☐ Student (Member A.P.A.) ..... **N.C.**
- ☐ Extra Banquet tickets @ $10.00 ea. .....

Total Amount Enclosed ..... $.....

Kindly reserve for the meeting of the

AMERICAN PODIATRY ASSOCIATION

August 22 - 26, 1958

Single Room and Bath	$9.00 Daily.....
Twin Bedroom and Bath	$13.00 Daily.....
Parlor, One Bedroom Suite . . .	$25.00 Daily.....

The Above Rates Include Free Garage Space and Children under 14 years of age in Same Room with Parents at No Extra Charge.

ARRIVAL DATE_____ TIME_____ DEPART_____

NAME _____

ADDRESS _____

Enclose this card with your check and send to:

American Podiatry Association
3301 16th St., Northwest
Washington 10, D. C.

Postage Will Be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY CARD
FIRST CLASS PERMIT No. 6499-R. WASHINGTON, D. C.

THE SHOREHAM HOTEL

2500 CALVERT STREET, N. W.

WASHINGTON 8, D. C.

▲ No information
● Not accepted
(2) Two (2) years
(1) One (1) by reciprocity

Missouri conducts examinations in two parts
A First Part after 2 years
B Second part after graduation

* Northwestern Institute
** Massachusetts School of Chiropody

State Board Reports—1956

Margin Number		Total Number Examinations		California College of Chiropody				Chicago College of Chiropody				New York College of Podiatry				Illinois College of Chiropody				Ohio College of Chiropody				School of Chiropody Temple University				Non-Accredited Schools				Margin Number
		M	F	M		F		M		F		M		F		M		F		M		F		M		F		M		F		
				P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	
1	Alabama	2	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	1
2	Arizona	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	2
3	Arkansas	1	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	3
4	California	32	..	7	..	..	..	2	..	..	..	10	..	..	..	4	..	..	..	6	..	..	..	3	..	..	..	..	..	..	..	4
(a) 5	Colorado	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	1	..	..	..	..	..	..	..	5
6	Connecticut	6	..	..	..	..	..	..	..	..	..	3	..	..	..	..	..	..	..	..	..	..	..	2	1	..	..	..	..	..	..	6
7	Delaware	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	7
8	Dist. of Columbia	6	3	..	..	..	..	..	..	..	..	2	..	1	..	2	..	..	..	..	..	..	..	1	1	1	1	..	..	..	..	8
▲ 9	Florida	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	9
10	Georgia	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	10
(b) 11	Idaho	1	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	11
(b) 12	Illinois	28	..	..	..	..	..	9	2	..	..	..	..	..	..	7	..	..	..	..	..	..	..	5	..	..	..	..	5	..	*	12
13	Indiana	6	1	..	..	..	..	2	..	..	..	..	..	..	..	3	..	1	..	1	..	..	..	..	..	..	..	..	..	..	..	13
14	Iowa	3	..	..	..	..	..	..	..	..	..	..	..	..	..	3	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	14
15	Kansas	2	..	..	..	..	..	..	1	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	15
● 16	Kentucky	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	16
17	Louisiana	2	..	..	..	..	..	1	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	17
● 18	Maine	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	18
19	Maryland	6	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	1	..	..	..	4	..	..	..	..	..	..	..	19
20	Massachusetts	10	..	..	..	..	..	..	..	..	..	1	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	8	..	..	**	20
21	Michigan	16	..	..	..	..	..	..	..	..	..	..	..	..	..	9	..	..	..	5	..	..	..	2	..	..	..	..	..	..	..	21
22	Minnesota	3	..	..	..	..	..	..	..	..	..	..	..	..	..	3	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	22
23	Mississippi	1	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	23
(b) 24	Missouri	3/4	..	..	..	..	..	1/2	..	..	..	..	..	..	..	2/2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	24
● 25	Montana	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	25
(b) 26	Nebraska	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	26
● 27	Nevada	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	27
28	New Hampshire	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	28
29	New Jersey	8	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	6	1	..	..	..	..	..	..	29
30	New Mexico	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	30
31	New York	47	1	..	..	..	..	..	..	..	..	45	1	..	..	..	..	..	..	..	..	..	1	..	1	..	..	..	..	..	..	31
32	North Carolina	4	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	2	..	..	..	1	..	..	..	..	..	..	..	32
● 33	North Dakota	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	33
34	Ohio	21	2	..	..	..	..	..	1	..	..	..	..	..	..	1	..	..	..	15	3	2	..	1	..	..	..	..	..	..	..	34
35	Oklahoma	2	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	35
● 36	Oregon	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	36
37	Pennsylvania	16	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	15	..	..	..	..	..	..	..	37
38	Rhode Island	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	2	..	..	..	..	..	..	..	..	..	..	..	38
● 39	South Carolina	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	39
● 40	South Dakota	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	40
41	Tennessee	2	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	41
42	Texas	11	..	..	..	..	..	1	..	..	..	..	..	..	..	2	1	..	..	4	2	..	..	1	..	..	..	..	..	..	..	42
● 43	Utah	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	43
44	Vermont	1	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	44
45	Virginia	2	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	45
46	Washington	1	..	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	46
47	West Virginia	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	47
● 48	Wisconsin	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	48
● 49	Wyoming	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	49
50	Hawaii	3	..	1	1	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	..	..	..	..	..	..	..	..	..	..	50
	Totals	260	7	9	1	..	..	21	4	..	..	63	1	1	..	47	2	1	..	43	7	2	1	45	4	1	1	8	5	..	..	

▲ No information
● No examinations
(a) Two (s) by reciprocity
(b) One (s) by reciprocity

Missouri conducts examinations in two parts
A First part after 2 years
B Second part after graduation

* Northwestern Institute
** Massachusetts School of Chiropody

controls. We regret to report that only two of the schools have so far cooperated in this matter. The Council on Education must reassert its position with respect to this recommendation if we are to function as an efficient and purposeful agency.

I wish at this time to extend special thanks to President-elect Dr. Jonas C. Morris, who was liaison officer between the Council on Education and the Executive Council.

Cooperation from the National Office was most helpful. Dr. Rubin and Mr. Fielding lent every assistance to the Council on Education, and it was through Mr. Fielding's efforts that we were able to obtain Dr. Goldthorpe from the United States Department of Higher Education.

It has been a pleasure to serve the National Association in my capacity as chairman of the Council on Education and to work with my colleagues from whom I received the fullest cooperation.

Respectfully submitted,
Stewart E. Reed, D.S.C., Chairman
Council on Education

D. V. Anderson, D.S.C.
E. W. Dobbs, D.S.C.
B. C. Egerter, D.S.C.
M. H. Gennis, D.S.C.
M. Marcus, D.S.C.
F. S. Schwarz, D.S.C.
H. Sonderling, D.S.C.
E. C. Stivers, D.S.C.
H. W. Weinerman, D.S.C.

To be possessed of good mental powers is not sufficient; the principal matter is to apply them well.

Descartes

TECHNIQUES IN FOOT SURGERY

L. R. McCAIN, D.S.C., F.A.C.F.S., and N. H. KETAI, D.S.C., F.A.C.F.S.
Editors, Publications Committee, A.C.F.S.

Illustrated case reports and discussions, suggesting approaches to podiatric surgery, from the files of the American College of Foot Surgeons.

SURGICAL CORRECTION OF FREIBERG'S INFRACTION OF THE SECOND METATARSO-PHALANGEAL JOINT

A FEMALE patient, aged thirty-one, presented on x-ray, a roughened enlargement of the second metatarsal head and base of the proximal phalanx of the second metatarso-phalangeal joint of the right foot. Roentgenograms also showed an idiopathic osteosis of the base of the proximal phalanx and the metatarsal head, with loose bodies present in the joint space.

There was a history of injury to the foot seventeen years earlier with slight discomfort. Three months before the patient's visit the foot had been reinjured and the patient was unable to bear weight without severe pain. Palliative therapy was not effective.

Findings were as follows: Hemoglobin 15 gm., 96%; W.B.C. 4,800; R.B.C. 5,020,000. Differential: Poly. seg. 48; Eosin. 2; Lymph 36; Monos. 2. The preoperative blood pressure was 118/78, and the oral temperature 98.6.

The patient was given Sodium Seconal®[1] gr. 1½ thirty minutes prior to the surgery.

Following sterile prep and the application of a Martin bandage, five cc. of Xylocaine®[2] 2% was infiltrated into the area.

Operative technic: A linear longitudinal incision was made on the dorsum of the foot extending from proximal of the second metatarsal head to the interphalangeal joint of the second toe, right foot. The incision was deepened with a combination of sharp and blunt dissection to the extensor tendon which was retracted laterally to gain access to the metatarsophalangeal joint. With continued sharp dissection the capsule was opened and the metatarsophalangeal joint disarticulated. The loose bodies of the joint space were removed, and with chisel and bone rongeur, the base of the proximal phalanx was removed and the proximal part of the shaft rounded and smoothed. Continued sharp dissection loosened the metatarsal head which was exposed sufficiently to allow for the removal of the lippings of the medial and lateral aspects of the metatarsal head with a bone chisel and bone rongeur. A collar of bone circumscribing the dorsal aspect of the head was removed in toto. This piece was evidently fractured during the recent injury. The head was reshaped and realignment attained. The capsule was closed with six 000 catgut sutures. Subcutaneous tissues and the tendon sheath were approximated and sutured with 000 catgut sutures. Skin closure was accomplished with nine 000 silk interrupted sutures. Sterile pres-

Fig. 1: Osteochondritis. Left—Before Surgery. Right—Following Surgery.

®[1] Lilly
®[2] Astra

sure dressing was applied to the foot.

The patient was given Nembutal®[3] gr. 1½ h.s., and Demerol®[4] 50 mg. PRN.

Postoperative treatment was as follows: On the second day dry sterile dressing was applied and the patient discharged from the hospital. On the eighth day, a dry sterile redressing with an elastic bandage was applied. Sutures were removed on the thirteenth day and redressed. On the seventeenth day Gentian Violet 2% was applied and redressed. At weekly intervals thereafter, hydrotherapy was administered and dry dressings applied. At the end of six weeks the patient was discharged surgically.

Meyer Berk, D.S.C.

Comments: This is the procedure of choice for the alleviation of this condition.

L. R. M. and N. H. K.

®[3] Abbott
®[4] Winthrop Laboratories

SURGICAL REMOVAL OF EXOSTOSIS DORSAL ASPECT MEDIAL CUNEIFORM

A FEMALE patient, aged fifty-six, presented an exostosis on the dorsal surface of the medial cuneiform of the right foot, with an accompanying heloma.

The patient had suffered prolonged discomfort in this area from shoes, and desired permanent correction.

Findings: Urinalysis, color—straw, character—clear, reaction—acid, Sp. G. 1.023, WBC—rare. Ep. cells—few. All else—negative.

Blood: Hemoglobin 83%, 12.9 gm.; W. B.C. 8,150; R.B.C. 4,230,000. Differential: Baso. 1; Eosins. 9; Segs 60, Lymphs 30.

The patient was given 1½ grs. Sodium Seconal®[1] preoperatively.

After sterile prep and the application of an Esmarch bandage, 3 cc. of 2% procaine with Wydase®[2] was infiltrated into the area.

Operative technic was as follows: A linear incision 3½ cm. long was made over, but slightly lateral to the exostosis. This was bluntly underscored and retracted. The deep fascia and ligaments were opened in the same manner and dissected away from the growth. At this time it could be seen that part of the growth was cartilaginous. The prominence was then removed with an osteotome (some cancellous bone was removed with it) leaving a slight depression. The area was then smoothed with a rasp. The dorsal ligaments and deep fascia were sutured with three medium chromic 000 interrupted sutures. The skin was closed with a combination of five 000 silk sutures of the vertical mattress and interrupted types. Sterile pressure dressing was applied.

The patient was given ½ gr. Codeine with ASA q 3 hrs. if necessary for pain, and 1½ grs. Sodium Seconal h.s. if needed.

Postoperative treatment was as follows: Two days postoperatively the outer dressings were removed and redressed. Seven days after surgery the sutures were removed, the area painted with Tincture of Merthiolate,®[3] and covered with a light dry dressing. On the tenth day the dressings were removed and the patient instructed to continue to wear a "cutout" shoe in order not to irritate the foot.

L. E. Krause, D.S.C.

Comments: This is a relatively simple procedure which may be used to remove a pressure area on the dorsum of the first cuneiform.

L.R.M. & N.H.K.

®[1] Lilly
®[2] Wyeth
®[3] Lilly

THE PODOPEDIATRIC CLINIC

JOHN T. SHARP, D.S.C.
Chairman, Committee on Children's Foot Health

This section is devoted to a discussion of the problems peculiar to the child's foot. A separate subject will be considered each month. Members are invited to send in their questions relative to the various phases of podopediatrics.

OSSIFICATION IN THE CHILD

SINCE so many of the conditons seen in childhood involve the bone structure, it is imperative that the podiatrist interested in podopediatrics be well informed regarding certain fundamental principles relative to bone and bone formation.

The bones of the extremities are derived from the mesoderm or middle layer of the primitive membrane. They are formed in sequence from precursor tissues of mesenchyme and cartilage. The conversion of mesenchyme into cartilage begins around the sixth week of fetal life. There are essentially two methods by which bone may ossify. The bones of the extremity are formed by the process commonly referred to as "endochondral" or "intracartilaginous" development. As these terms suggest, this method of ossification is one in which the bone is formed in a pre-existing layer of cartilage.

The individual bones may be formed entirely from a single or "primary" center of ossification, or they may be developed partly by this original nidus and partly by other "secondary" centers. For example: all of the tarsal bones, with the exception of the calcaneus, are usually formed by a primary center only. The metatarsals, on the other hand, are formed only in part from a primary center (occurring in the shafts of the bones), the balance of bone growth taking place in secondary centers located in the epiphyses. This same procedure is common to the phalanges.

In any consideration of osteogenesis, mention must be made of the extremely important role played by the endocrine glands. The members of the endocrine system having an influence upon bone growth are as follows:[1]

The thyroid—which is concerned with the regulation of the pre-osseous cartilage.

The anterior lobe of the pituitary—which stimulates the osteogenetic centers during the period of active bone growth.

The gonads (Sex glands) whose secretions aid in bringing about the union of epiphysis and diaphysis, thus making the cessation of bone growth possible.

The parathyroids—which are primarily concerned with calcium metabolism and calcium-phosphorus balance.

Needless to say, malfunction of these glands results in abnormalities of bone formation. These abnormalities will vary with the particular gland or glands involved. The following are examples of some of the aberrations resulting from endocrine disturbances:

Hyperfunction of the anterior lobe of the pituitary may result in either delayed epiphyseal closure, or gigantism.

Hypofunction of the thyroid may give rise to failure of epiphyseal closure, delay in ossification, and dwarfism.

Hypofunction of the gonads results in marked delay in epiphyseal closure, which in turn resolves itself in gigantism.

Hyperfunction of the parathyroids—which produces osteoporosis, abormal bone formation, and hypercalcemia.

In general, we may say that endocrine disorders produce skeletal abnormalities either by interfering with normal cartilage

or bone development or by disturbing normal calcium and phosphorus metabolism.

The clinical approach to bone examination either for determining the state of ossification or for investigating bone pathology is of course made through the medium of the x-ray. Although most of us are familiar with the normal appearance of the various foot bones on the roentgenogram, there are certain normal variations incident to bone formation in the child which are worthy of note. The more important of these are as follows:

The apophysis of the calcaneus may *normally* present increased density. It may and usually does develop from multiple centers, a factor which is often confused with fragmentation. The apophysis is normally an area of irregular mineralization. The calcaneal apophysis appears in boys between the 6th and 10th years and in girls between the 6th and 8th years.[2] It is seen primarily in the area of the distal one third of the posterior surface of the calcaneus. In most instances, about seven years are required for full development and fusion of the apophysis.[2] The occurrence of increased density and segmentation in the normally developed apophysis is so common that many authorities are seriously questioning the existence of "Sever's Disease" or "Apophysitis" as a pathological entity.

The navicular may, like the calcaneal apophysis, also ossify from multiple centers. In a recent investigation, over one third of a series of one hundred cases examined displayed naviculars which developed from more than one center.[2] In cases where a single center of ossification exists for the navicular, it appears quite early, usually about the second year. When multiple centers exist they usually appear later, in most instances around the fourth year.

The first cuneiform may also develop from multiple centers of ossification.

The posterior margin of the body of the calcaneus, which is to say that area adjacent to the apophysis, is normally roughened and indented in the child.

In general, ossification is more advanced in girls than in boys. The fusion of the epiphyses with the bodies of the bones occurs earlier in girls than in boys.

The primary centers of ossification for the calcaneus, talus, metatarsals and phalanges all appear in intra-uterine life. The center for the cuboid is variable—sometimes appearing in pre-natal life and in other instances arising as late as the first post-natal year. The cuneiforms and the navicular bones all present centers which primarily begin ossifying after birth. This is also true of the secondary centers of the metatarsals and phalanges (epiphyses).

The epiphyses of the proximal and middle phalanges fuse with their respective shafts between the twelfth and twenty-second years; those of the distal phalanges fuse between the eleventh and twenty-second years.

Fusion between the epiphyses and shafts of the metatarsals occurs between the thirteenth and twenty-second years.

Although space does not permit a detailed consideration here, the podiatrist who is desirous of dealing with children should familiarize himself with the various accessory bones commonly seen in the foot. A knowledge of these bones and their locations aids in differentiating between normal bone variations and actual fractures.

1424 Old York Rd., Abington, Pa.

Bibliography

[1] de Lorimier, Alfred A., Moehring, Henry G., and Hannan, John R.—"Clinical Roentgenology," Vol. 1 (Charles C. Thomas).

[2] Ferguson, Albert B., Jr., and Gingrich, Ralph Max—"The Normal and the Abnormal Calcaneal Apophysis and Tarsal Navicular," Chapter 8 in "Clinical Orthopedics," Number 10, De Palma, Anthony F., et al (J. B. Lippincott—Phila.).

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

CAL-O-B Tablets

Description: Calcium glycerophosphate 500 mg., ferrous gluconate 200 mg., vitamin D_2 (Calciferol) 1000 Units, pyridoxine HCl 1 mg., ascorbic acid 50 mg. and 12 trace minerals including fluorine and cobalt.

Properties: The only known phosphated calcium that is efficiently absorbed at duodenal pH.

Indications: Orthopedic problems involving demineralization or osteomalacia.

Advantages: Calcium glycerophosphate —a definite advancement over the phosphorus-free calcium compounds—a new type of phosphorus that helps calcium assimilation—for bone health, calcium that is utilized—with minimal amounts lost down renal drain. Calcium glycerophosphate produced greater calcium deposition in bone and greater bone strength than any of the other phosphated or phosphorus-free calcium compounds. Antacid properties that interfere with calcium absorption less than for any other calcium compound tested against bromphenol blue.

Dosage: 1 tablet twice daily.

Supply: Bottles of 100 tabs. By Warren-Teed Products Company, 582 W. Goodale Street, Columbus 8, Ohio.

Application: According to clinical information available, Domeboro wet dressings are especially valuable in acute dermatitis if there is vesiculation accompanied by oozing and crusting. It is the preferred local treatment in such conditions. Usually soaks are preferable for eruptions of the hands or feet and compresses for other sites. In either case, the patient is instructed to apply treatment 3 or 4 times daily for about 15 minute periods. Compresses or soaks often remove crusts and other debris and are antipruritic.

Chamo-Powder

Description: Chamomile Flower Solution. Each Chamo-Powder packet contains sufficient specially prepared water soluble extractives of whole chamomile flowers that, added to one pint of ordinary tap water, produce a chamomile solution embodying the time-tested anti-inflammatory, antihistaminic properties of the natural azulene of chemomile and the mildly astringent properties of other natural ingredients of this medicinal flower.

Advantages and Uses: This is a convenient, instantly available preparation for utilizing the natural mild antihistaminic, antiphlogistic, antipruritic and keratolytic properties of chamomile flowers, especially in acute, subacute and chronic stages of inflammatory dermatitis where stronger measures may provoke sensitivity.

NOTE: Any acute contact dermatitis, whether it is due to chemicals, plants, or physical agents, is benefited to some extent by properly applied, bland wet dressings. Chamo-Powder wet dressings relieve local discomfort and pain by "modifying the inflammation through constrictor effect on the skin capillaries."

Indications: In subacute, acute and

chronic dermatoses and in contact dermatitis caused by an externally contacted sensitizing agent or chemical irritant, especially when mild, conservative anti-inflammatory, antipruritic management without risk of provoking sensitivity is required.

Directions: Dissolve one packet in a pint of ordinary tap water and use as a wet dressing, soak or sitz bath.

Supply: Boxes of 12 and 100 individual powder packets. By Dome Chemicals Inc., 109 W. 64th Street, New York 23, N. Y.

Wright's Liquor Carbonis Detergens

Description: Wright's Liquor Carbonis Detergens is an improvement on the crude coal tar ointment of Goeckerman—as effective as the original but simpler to use and more acceptable. It is an alcoholic solution of coal tar produced in accordance with the continental formula for Wright's Liquor Carbonis Detergens.

Action and Advantages: This preparation provides all the therapeutic advantages of crude coal tar without the usual messy and unpleasant features. It is nonsettling and causes far less staining than other liquid tar preparations. It is useful in ointments and lotions or undiluted for painting lesions, is easily incorporated into ointments and lotions. It is valuable in a wide range of cutaneous disorders. In Psoriasis, it is helpful and efficient without the disadvantages occasioned by the use of the crude coal tar ointment. Daily application of full-strength liquor carbonis detergens is in itself, even without ultraviolet light, very helpful in many cases. This preparation is soothing and is valuable for its antipruritic action.

Application: Apply undiluted to the lesions once or twice daily with an ordinary one inch (1") paint brush. The desired concentration may be easily incorporated into cosmetically acceptable ointments and lotions. For tar baths—in generalized dermatoses, 2 or 3 ounces of Wright's Liquor Carbonis Detergens may be stirred into the bath water, or the patient may be painted with the undiluted medication just before immersion in a warm bath.

Supply: Available in 3 oz., 8 oz., and 16 oz. bottles. By E. Fougera and Company, Inc., 75 Varick Street, New York 13, N. Y.

Typical Prescription:

Wright's Liquor Carbonis Detergens 5%
Polysorb (Fougera) q.s. 120.0 cc.

NOTE: POLYSORB is a hydrophilic ointment base useful for all dermatologic prescriptions. Polysorb appears to be most applicable to general dermatological practice. It produces no sensitivity nor irritation, either alone or in combination with drugs, in both animal and human skin studies. Polysorb had no incompatibilities, according to clinical study, with the commonly used dermatological agents. Polysorb does not interfere with the process of skin repair and may be used freely by patients having a known allergy, since it is not sensitizing.

Bur-Veen

Description: Wet dressings for the therapeutic effect of Burow's solution.

Composition: Aveeno Colloidal Oatmeal, aluminum sulfate, calcium acetate (combines in solution to make modified Burow's Solution with Colloidal Oatmeal).

Action and Uses: Wherever Burow's Solution is indicated; for weeping, inflamed, acute, skin conditions. Supplies the therapeutic effects of Burow's Solution plus the soothing effect of the colloidal protection of Aveeno Colloidal Oatmeal.

Administration and Dosage: One (1) packet added to 1 pint of water makes the equivalent of 1:20 Burow's Solution in a medium of soothing Aveeno Colloidal Oatmeal. Dilution may be varied as desired.

Supply: Boxes of 6 and 100 packets. By Aveeno Corporation, 250 West 57th Street, New York 19, N. Y. (Distributors, E. Fougera & Co., Inc.)

PODIATRY-CHIROPODY ABSTRACTS

ROBERT SHOR, D.S.C.
LOS ANGELES, CALIF.
Chairman, Committee on Publications

Editors of Local, State and Regional Publications are requested to provide copies to the Chairman of the A.P.A. Committee on Publications who is preparing this section of the Journal.

TREATMENT FOR HELOMA MILLIARE

M. A. Kleiman, Footprints (Fla. Chir. Assn.), 4:1. Jan. 1958.

A simple empiric treatment for plantar helomata that occurs either directly under or between the metatarsal heads is outlined. After debridement, a pad with an aperture slightly larger than the heloma is placed on the foot. The aperture is filled with 10% silver nitrate ointment and covered with webril. Place a plug about one and one-quarter inches long and one inch wide along the shaft of the metatarsal. This plug must be placed at least one-half inch posterior to the head of the bone. The whole area is then covered with moleskin.

Kleiman states that this type dressing gives patients greater comfort for a longer time and that the results are gratifying.

THE EFFECT OF CIRRHOTIC LIVER ON CIRCULATION

W. G. Mabin, Chiropody Record, 1-2:5-6. Jan.-Feb. 1958.

The size of the liver in cirrhosis is related to the degree of fibrosis and contraction, the presence and degree of a casual or an associated fatty metamorphosis, and the presence and degree of a casual or an associated inflammation. In view of the possible pathological involvements described, Mabin states that great caution should be exercised in applying vaso-dilating therapy for faulty lower extremity circulation. If the presence of such complications are suspected, chiropodists should ascertain: clotting time; blood for bilirubin analysis; dorsalis pedis and popliteal pulses and oscillometric readings; and patient should be referred to physician for further check-up.

ULCERS AND INJECTION THERAPY

A Case Report, J. A. Corsaro, Footprints (Fla. Chir. Assn.), 4:2. Jan. 1958.

Corsaro presents a case report on a 60-year-old patient with a diagnosis of Thrombo-phlebitic Ulcer, acute. The ulcer improved and healed with the use of Parenzyme (National Drug Co.), this injectable agent being the proteolytic enzyme "trypsin," in a sesame-oil suspension. One c.c. (5 mg. Parenzyme) was injected intra-muscularly in the gluteal region daily for 5 consecutive days, then cut down to alternating days for 4 more injections. By the third injection there was a definite improvement with the ulcer beginning to show signs of closure. Each succeeding injection continued to show improvement until the ulcer was completely healed.

GERIATRICS IN CHIROPODY

B. Tanner, Footprints (Fla. Chiropody Assn.), 4:15. Jan. 1958.

When an elderly individual enters your office the word "caution" should govern your entire method of treatment. A good axiom to follow is, "there is a direct proportion between their health and what you can do for them." Your general examination should elicit as much information as possible with a special interest in heart and kidney diseases and emphasis on circulatory problems and arthritis.

Tanner divides his treatment into what he calls the 4 P's—Prophylaxis, Palliative, Prognosis, and Psychology. Each phase is discussed.

SOME AFFECTIONS OF THE MUSCLES

Austin Furniss, The Brit. Chir. J., 3:62-68, March, 1958.

The more common conditions of the muscles are grouped under the name of the myopathies. The muscular dystrophies form a group of diseases in which no change has been discovered other than in the muscles themselves. The creatin tolerance is known to be low, but whether this is cause or effect has not been established. It is usual to describe three main types, but the types may be mixed. 1. Pseudo-hypertrophic (Duchenne)—this is the commonest variety. 2. The juvenile type (Erb's) and 3. The fascio-scapulo-humeral type (Landouzy-Dejerine). The chief feature of all the myopathies is muscular weakness without paralysis. There is no reaction of degeneration, but the response to electrical stimuli is almost invariably diminished, while the reflexes are diminished or absent according to the degree of change in the affected muscle. Sensory changes are never present.

Furniss describes the above types of myopathies and discusses the pathology, diagnosis, prognosis, and treatment of these conditions. He further discusses Myasthenia Gravis, Myositis Ossificans Progressiva, Dermatomyositis, and the Myotonias.

SURGICAL CORRECTION OF HELOMA DURUM RESULTING FROM IMPROPER FOOTGEAR

Robert L. Brennan, Canadian Pod. J., 2:6-8. April 1958.

Surgical correction of heloma durum 5th gives relief from pain and objective symptoms, and permits the patient to wear high style shoes again.

A transverse incision is made through the skin across the dorsal interphalangeal articulation. The skin is retracted and a longitudinal incision is made through the capsule dorsally over the joint. The capsule is reflected from the joint by sharp dissection. The ends of two curved mosquito hemostats are directed plantarly against the medial and lateral surface of the middle or distal phalanx, and the bone is pried gently into view. With a small bone forceps, enough bone is removed from the borders of the joint to insure correction of the hammertoe. The skin is approximated and the skin is closed 4-0 or 3-0 silk sutures.

Dr. Brennan discusses other surgical treatments for heloma durum or hammertoes and states that these procedures afford extremely satisfactory results and make it again possible for the patient to wear shoes of choice.

EPIDERMOID CYST

Harold Sarles, 22:2-3, Indiana S. Pod. J., April 1958.

A case history in reference to a seven-year-old boy who, approximately one and one-half years ago, fell on a nail and lacerated the posterior aspect of the left heel. The laceration healed with no complications. In the past two weeks this area has become painful when wearing a shoe. Examination revealed a rounded cyst-like swelling, easily palpable and movable and attached to the under surface of the skin. After local anesthesia was infiltrated a semi-elliptical incision was made over the site and the adjacent skin flaps were bluntly dissected away from the cyst. The cyst was removed in toto and revealed a very heavy, white walled sac with a thick black exudate, exuding from it.

The operated wound healed with no complications.

(Reprint N. Y. J. of Pod., Nov. 1956.)

DIGESTS FROM THE LITERATURE

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

ANESTHESIA

Local Anesthetics, J. Adriani. Merck's Seminar Report 1: 320-21, Fall 1956.

The number of untoward reactions to use of local anesthetics is greater than surmised. Excepting cocaine, local anesthetics are synthetic with amino-nitrogen reacting with organic and mineral acids to form alkaloids. Many have varying degrees of anti-histaminic, anti-cholinergic and even curare-like activity. Usefulness of the agent depends on its solubility, potency and toxicity. Unless water soluble it does not pass into nerve tissue. Untoward responses can be either local or systemic. Transient or permanent damage may occur. Systemic reactions are due to the presence of the agent in the circulating blood. Even a local anesthetic ultimately passes into the blood stream. When concentration in the blood exceeds the tolerable level, symptoms of toxicity occur. Medullary depression with respiratory failure and convulsions may occur, preceded by excitement, apprehension, disorientation, nausea or vomiting. Short-acting barbiturates are ideal for controlling convulsions. They should not be used for reactions such as depression, coma, respiratory failure or circulatory failure. Barbiturate premedication in ambulatory patients undergoing minor surgery is contraindicated. A local anesthetic should not be administered unless a short-acting injectable barbiturate, a vasopressor, or an effective method for performing artificial respiration is at hand. Some patients are intolerant to local anesthetic drugs; others become sensitized to repeated exposure to the drugs, developing urticaria, eczema, laryngeal spasm, tongue swelling, or bronchospasm. The reactions are generally due to use of an excessive quantity. Vasoconstrictures should not be used when blocking fingers, toes or other appendages. Reactions occur most often in debilitated adults, in infants and in children. Anesthetics should not be injected into inflamed areas.

CIRCULATORY SYSTEM

Effect of Limb Position and of Venous Congestion on the Circulation through the Toes, R. M. England and J. C. Johnston. Clin. Sci. 15: 587-92, 1956.

With the subject lying prone on a couch, with each leg supported by a flap hinged below the hip joint, when a venous congesting cuff at the ankle was inflated, the transmural pressure in the blood vessels was increased, and also when the leg was lowered from horizontal to dependent position. Resistance of blood flow was calculated by following the circulation through the toes. The amount of heat eliminated was reduced in the congestion experiments in direct proportion to the congesting pressure when it exceeded a value of about 30 mm. Hg. However, with the leg in dependent position heat elimination from the toes was significantly increased. In neither experiment was there evidence of reflex vasoconstriction on lowering the limb. The fall in heat elimination during the five minutes after the limb was raised from the experimental position may result from a persistent increase in contractile tone after removal of the distending stimulus. Evidence seems to suggest a small decrease in resistance to flow and therefore a slight vasodilatation of the resistant vessels when the limb is dependent.

DERMATOLOGY, ALLERGY, FUNGUS DISEASES

Treatment of Certain Dermatoses with a Collodial Wet Dressing, S. Fisher. J. New Jersey M. Soc. 53: 592-94, 1956.

Of 309 patients with dermatitis treated with Bur-Veen®, which is Burow's solution with Aveen added, 97 per cent showed good to excellent results. These cases were chiefly contact dermatitis (70 cases), dysidrosis (28), pyoderma (23) and seborrheic dermatitis (20). A package of Bur-Veen wet dressing powder added to one pint of tap water was used for periods up to two hours several times a day. The possibility of irritation which follows use of ordinary wet dressings was much reduced, even when used for long periods.

Tinea Pedis as a Source of Infection in the Family, S. Rothman, G. Knox, and B. Windhorst. Arch. Derm. 75: 270-71, 1957.

A man with T. rubrum infection of the right third toe, the heel and the interspaces of both feet, placed his foot on the toilet seat while treating his dermatosis. His wife acquired a tinea circinate of the left buttock. A patient with this infection should be warned of its contagiousness.

Finaf, a New Cutaneous Fungicide, B. H. Kuhn, Arch. Derm. 76: 627-68, 1956.

Sixty-five patients with dermatomycosis were treated with Finaf, which consists of 5.5% salicylic acid and 3% crystallized cupric sulfate in a base of isopropyl alcohol and water. Only 9% failures were reported. In cases of tinea versicolor 100% were cured in two weeks.

Trichophytin Reaction after Exposure to Dermatophytes, H. Rogachefsky, et al. Arch. Derm. 75: 606-09, 1956.

Massive exposures to dermatophytes were made to the feet of 72 human volunteers. Results showed that such fungous exposures can produce or reawaken trichophytin sensitivity in many subjects, as revealed by skin tests, but did not engender discernible fungous disease in the subjects. It is suggested that the sensitivity had been dormant and had been awakened, or that other mechanisms might account for the change in trichophytin reactions.

Isolation of Dermatophytes from Floors of Communal Bathing Places, J. C. Gentles. J. Clin. Pathol. 9: 374-77, 1956.

A method of isolating dermophytes from shower floors is described. Isolations made from each place sampled showed that these fungi are present to some extent on floors of communal bathing places. It is not clear whether the dermatophytes are present on the floor as saprophytes or in skin fragments. But there is little possibility that saprophytic colonies are formed, because of frequent use of disinfectants on the floors.

DRUG THERAPY

Absorption of Hydrocortisone from the Joint Cavity into the Circulation, H. Oka. Ann. Rheumat. Dis. 15: 327-29, 1956.

Intra-articular hydrocortisone therapy is being extensively used for local palliation, but that it has no systemic effects is untrue. Absorption into the blood of injected hydrocortisone was studied in six patients with rheumatoid arthritis or osteoarthritis of the knee. It was found that the drug was absorbed into the circulation to a considerable degree. High 17-hydrocorticosteroid values were obtained after injection of 25 to 100 mg.

MUSCULOSKELETAL SYSTEM

Osteochondritis of the Medial Sesamoid of the Great Toe, C. G. Attenborough. Proc. Roy. Soc. Med. 49: 809-11, 1956.

Three patients with this disorder have been reported. Radiographic appearances in these patients showed typical changes of osteochondritis in its various stages—first, early fragmentation and flattening, then development of sclerotic areas, followed by further fragmentation, and finally the appearance of bony islands fused together as re-ossification occurs, leaving some permanent flattening.

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

COLORADO

At the annual meeting of the Colorado Association of Chiropodists held in Denver April 27, 1958, the following officers were elected: President, Carl Ritz, D.S.C., Denver; President-elect, W. Lynn Farrell, D.S.C., Ft. Collins; Vice President, Hy Rosenfeld, D.S.C., Denver; and Executive Secretary-Treasurer, Mrs. Lou I. Lorett, Englewood. Dr. George D. Patton was re-elected to serve as Delegate to the National Association meetings and Dr. Charles P. Lorett was re-elected to serve as Delegate to the Region Six meetings.

ILLINOIS

Zone III

The quarterly meeting of Zone III, Illinois Chiropody Society, was held Sunday, March 2, 1958, at the Jefferson Hotel, Peoria, Illinois. The following officers were elected to serve during 1958-59: President, Dr. George Geppner, Peoria; President-elect, Dr. J. T. Baldwin, Kankakee; Secretary-Treasurer, Dr. J. T. Baldwin, Kankakee; Delegates Drs. W. Jackson, Rockford, and J. Lehman, Galesburg; Alternate Delegates, Drs. George Guenzler, Freeport, and C. J. Meyer, Galesburg; Sgt.-at-Arms, Dr. W. Anderson, Danville; Scientific Chairman, Dr. R. Shaw, Galesburg.

The speaker for the afternoon scientific session was Dr. Joseph Doller, Chicago, Illinois, who lectured on "Office Technique for Fracture Immobilization."

IOWA

The Iowa State Chiropody Association will hold a semi-annual meeting in Des Moines at Hotel Savery, June 7 and 8. Speakers in the scientific sessions will be: Dr. R. E. Holdeman of Cedar Rapids—"Treatment and Management of Nails via Use of Acrylics"; Dr. E. S. Thompson of Davenport—"A New Approach to Forefoot Padding Problems"; Dr. C. L. Meyer of Galesburg, Illinois—"Short Cuts in Lab Techniques for the Prefabrication of Appliances"; Dr. S. R. Gottler of Monmouth Illinois—"Office Economics."

Business sessions will be held on June 8 with President C. B. Dunshee of Oskaloosa presiding. Candidates for the Iowa Chiropody Board examinations to be held on June 9, 10 and 11 will be guests of the Association at the two-day meeting. The Iowa Ladies' Auxiliary will also hold its semi-annual meeting.

KENTUCKY

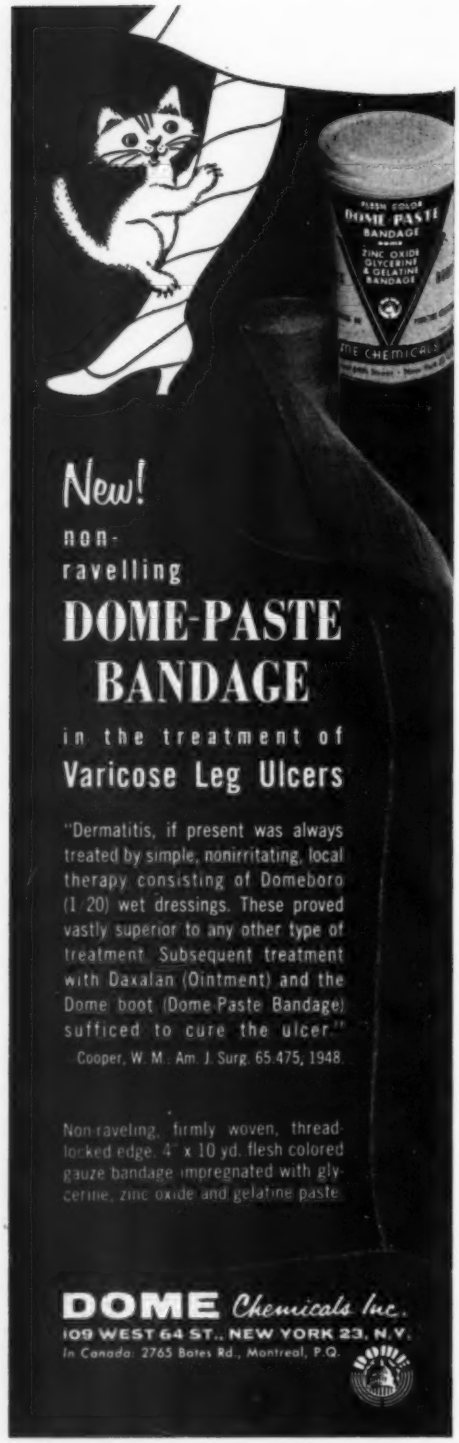
At the Spring meeting of the Kentucky Association of Chiropodists the following officers were elected: President, L. D. Oppenheimer, Jr., D.S.C., Covington; President-elect, R. P. Stivers, D.S.C., Louisville; First Vice President, W. B. Froehling, D.S.C., Lexington; Second Vice President, A. G. Quade, DS.C., Ashland; Secretary, C. A. Nava, D.S.C., Louisville; Treasurer, Rose M. Stivers, D.S.C., Louisville; Treasurer, U. Z. Litsey, D.S.C., Louisville; Delegate, E. C. Stivers, Sr., D.S.C.; Alternate, C. A. Nava, D.S.C.

J. H. Gruber, D.S.C., D. M. Pletcher, D.S.C., and R. L. Woodard, Jr., M.D., all of Louisville, presented papers for the scientific program.

E. C. Stivers, Jr., D.S.C., announced his retirement from the practice of chiropody to enter the insurance field. An unusual sequel has occurred, in that E. C. Stivers, Sr., D.S.C., before entering chiropody was in the insurance field and now his son is reversing the situation. In recognition of his service to the profession, Ed, Jr., was awarded an honorary membership in the Association. His active membership expires in June, 1958.

MINNESOTA

The Association held its quarterly meeting in Hopkins, Minnesota. A portion of the meeting was devoted to discussing the problems of running our chiropody col-


DOME PASTE
BANDAGE
ZINC OXIDE
GLYCERINE
& GELATINE
BANDAGE
New!
non-
ravelling
DOME-PASTE
BANDAGE
in the treatment of
Varicose Leg Ulcers
"Dermatitis, if present was always treated by simple, nonirritating, local therapy consisting of Domeboro (1:20) wet dressings. These proved vastly superior to any other type of treatment. Subsequent treatment with Daxalan (Ointment) and the Dome boot (Dome-Paste Bandage) sufficed to cure the ulcer."
Cooper, W. M.: Am. J. Surg. 65:475, 1948.
Non-raveling, firmly woven, thread-locked edge, 4" x 10 yd. flesh colored gauze bandage impregnated with glycerine, zinc oxide and gelatine paste.
DOME Chemicals Inc.
109 WEST 64 ST., NEW YORK 23, N.Y.
In Canada: 2765 Bates Rd., Montreal, P.Q.

leges, some of the basic reasons for the problems and possible solutions.

The scientific program consisted of demonstrations and lectures by Dr. Tom Yard of Burlington, Iowa, and Drs. Chrencik and Ueland of Minnesota. There was a demonstration of new disposable type syringe and needle, and a film on "The Meti-Steroids in Rheumatoid Arthritis" was shown.

OKLAHOMA

At the meeting of the Oklahoma Chiropody Association, Inc., April 6, 1958, in Oklahoma City, the following officers were elected: President, Dr. Donald Landrum, Tulsa; President-elect, Dr. Earl Weibel, Oklahoma City; Vice Presidents, Dr. Eugene Gardner of Midwest City and Dr. O. R. Donoho of Ardmore; Secretary, Dr. H. R. Johnson, Shawnee; Treasurer, Dr. Milton Gennis, Tulsa; Board of Governors, Dr. Ralph Owens, Oklahoma City, Dr. Harry Bonnell, Ponca City, Dr. A. D. Conley, Tulsa, Dr. Lafe Midkiff, Oklahoma City, Dr. Jeane Johnson, Enid; Delegate, Dr. Howard Johnson, Enid; Alternate, Dr. Ralph Owens, Oklahoma City. Dr. Warren D. Long of Oklahoma City was re-elected to the State Board of Examiners.

PENNSYLVANIA

On April 15, the monthly scientific meeting of the Philadelphia Chiropody Society was held at the County Medical Society Building. The evening's program, under the supervision of Dr. William Packman, was devoted to "Practical Chiropody—Gadgets and Gimmicks."

Guest speakers were Drs. Alan A. Pasternack, Gerald V. Feldman, Stanley Landau and Paul Schneyer.

CHICAGO COLLEGE OF CHIROPODY

The Chicago College of Chiropody will hold a two-day postgraduate course in surgical and dissecting anatomy correlated with anesthesia techniques and surgical landmarks. The course will be conducted by Dr. Kurt L. Eichelbaum, M.D., Dean. For further information write to Dr. Herman G. Miller, Registrar, 1422 W. Monroe Street, Chicago 7, Illinois.

TEMPLE UNIVERSITY

Temple University, School of Chiropody, will sponsor under the auspices of The American Society of Chiropodical Roentgenology, a post graduate course devoted to Roentgenology. This course will cover 30 hours, and credits may be applied to the post graduate certificate as offered by the University and for which some people have been studying. Classes will commence early in the fall of 1958. Further information can be obtained by writing Dean Charles E. Krausz, 1810 Spring Garden Street, Philadelphia 30, Pa.

LEGAL AND LEGISLATIVE

CALIFORNIA

The Chairman of the Board of Trustees of California Physicians Service advised the California Association of Chiropodists through President Jacobi of the following:

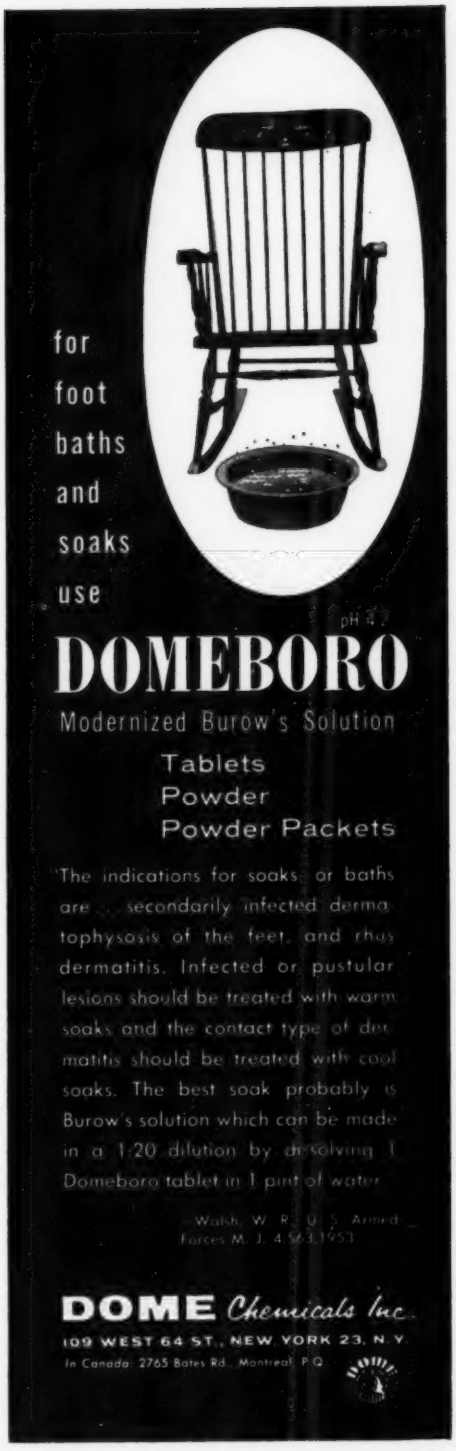
"After careful consideration, the Board of Trustees of CPS passed the resolution that CPS will pay for the services of Chiropodists for in-hospital surgical benefits when performed in a licensed hospital. Payments will, of course, be made in accordance with the fees established by CPS."

MASSACHUSETTS

FLUOROSCOPIC shoe-fitting machines are banned except for diagnosis and treatment, in emergency legislation signed by the Governor of Massachusetts on February 17, 1958. The Act (Chapter 79), which amends Chapter III of the General Laws, reads in part:

"No person shall operate or maintain a shoe-fitting device or machine which uses fluoroscopic, X-ray or radiation principles, except for diagnostic or therapeutic purposes by or under the direction of a physician or chiropodist (podiatrist) registered under the laws of the Commonwealth (of Massachusetts)."

HOUSE BILL 2292 has been withdrawn by mutual consent and new legislation is planned to be submitted at a later date in the Massachusetts State Legislature regarding the taking of impressions of the foot for custom made shoes.


for
foot
baths
and
soaks
use
pH 4.2
DOMEBORO
Modernized Burow's Solution
Tablets
Powder
Powder Packets
"The indications for soaks or baths are ... secondarily infected dermatophysosis of the feet, and rhus dermatitis. Infected or pustular lesions should be treated with warm soaks and the contact type of dermatitis should be treated with cool soaks. The best soak probably is Burow's solution which can be made in a 1-20 dilution by dissolving 1 Domeboro tablet in 1 pint of water.
—Walsh, W. R., U. S. Armed Forces M. J. 4:563 1953
DOME Chemicals Inc.
109 WEST 64 ST., NEW YORK 23, N. Y.
In Canada: 2765 Bates Rd., Montreal, P.Q.

WOMEN'S AUXILIARY

To you busy doctors—May I have a moment of your time?

Don't you believe your wife can be a valuable asset to you in your profession? If so—How best can she assist you? First, and foremost, by an interest in the organizations that are allied to your professional organizations. Shall I give you some reasons why?

1. She will be with other women who have similar interests at heart.
2. With others she will be able to exchange ideas.
3. In a group, projects can more easily be accomplished and will be much more interesting.
4. Good public relations and public education can be established through your women's organizations.
5. Meetings can be an interesting stimulus to everyday life. We all need interests outside of our daily routine to keep us on our toes and not to let us just vegetate and grow stale.

Let your wife know you would like her to belong to the auxiliary. If you have no auxiliary in your area find one woman who is a good organizer. We'll be glad to send her the necessary information and help in any way possible to get a group started. You show me an area with an interested women's organization and I'll show you a strong, more congenial men's organization.

Remember your wife has the best interest of you and your profession at heart. It is to her advantage to do all in her power to educate the public to the value of your profession.

So—all of you—get behind us and give us your assistance for a larger, more active and interesting women's auxiliary.

"Divide and conquer" may be a good solution to solving big problems but "In Numbers There Is Strength" should be our motto.

Thelma Cooper, R.N., President
Women's Auxiliary

DEATHS REPORTED

William D. Cogan
Cambridge, Mass.

William P. Embry
Wilson, N. C.

COMMUNICATION FROM THE MUSEUM COMMITTEE

The secretary of each state association or state society is hereby appointed and authorized to become temporary acting local chairman for the National Museum.

His duties are to contact the relatives, or next of kin, of any chiropodist who passes away in his or her locality and to formally request the items that we desire:

Old chiropody equipment; A.P.A. state or zone convention programs; A.P.A. state or zone convention group photographs; Old and unusual chiropody instruments; Old instruments (used by donor); Any and all books pertaining to feet, written or owned by donor; Donor's photograph; Donor's biography; Copy or business stationery, letterhead, professional cards, etc.; X-rays or photographs (before and after surgery or treatment of unusual cases); Mechanical devices used in profession; Old appliances for unusual or rare conditions; Unusual shoe build-ups—unusual shoes.

It is urgent that individual members in your state be alerted to advise the Museum Committee of any such items mentioned above, with the name and address of the doctor for whom it is being contributed.

A suggestion to the membership: A member can make a will now directing the disposal of items suitable for the Museum or personally instruct the nearest of kin to the end that the Museum will not be forgotten. The Museum is seeking nothing of current value—only items of historic value. Remember, other professions have museums relative to their professions; the success of our Museum depends entirely upon the cooperation of each and every member.

Dr. George W. Nelson
Minneapolis, Minnesota

STELLA'S STRETCH-ALL®

A LIQUID PREPARATION GUARANTEED TO STRETCH PERMANENTLY ANY SHOE MADE OF LEATHER, IN LENGTH OR WIDTH.

WILL NOT SPOT, SPLIT OR CRACK THE FINEST OF LEATHER

Free
Sprayer Included
Pints & Quarts

STELLA'S STRETCH-ALL

Send name and address of your supplier for free sample.

F. P. Stella & Sons Products
New Buffalo, Mich.

THE FUNGUS DIAGNOSTIC SERVICES AND LABORATORY

FOR RAPID AND ACCURATE DETERMINATION OF THE PRESENCE OF FUNGUS INFECTION SIMPLY MAIL IN SKIN SCRAPINGS, BLISTER TOPS, OR NAIL CLIPPINGS. COLLECT ON, AND FOLD INTO A SHEET OF PAPER. EASIER THAN A BIOPSY, SURER THAN A GUESS. INQUIRIES INVITED.

H. C. GOLDBERG, M. D.
DIPLOMATE AMERICAN BOARD OF DERMATOLOGY

7 WATCHUNG AVENUE
PLAINFIELD, N. J.
PL 6-7645

PENNSYLVANIA MEMBERSHIP COMMITTEE REPORT

The Membership Committee has been extremely busy this year and the results are becoming apparent. Most Chairmen are reporting a substantial number of new members with the greatest increase in Northwestern Division.

A closer liaison has been established with the Membership Committee of the A.P.A. which should be advantageous to both the National and State Committees. The National slogan, "Membership Is A Privilege," has been adopted by your Membership Committee because it indicates our basic thinking regarding membership.

With the complete cooperation of our Editor, Dr. Allen E. Forsythe, the fourth annual "Membership Issue" of the Journal was published in February of this year. This has been of immeasurable value toward the cause of membership, judging from the many favorable comments we have received, not only from prospective members, but from Membership Chairmen in other States and the A.P.A. We extend our sincerest thanks to Dr. Forsythe and all of the others who have made a continuation of this work possible.

As we have done in the past—a copy of the "Membership Issue," a congratulatory letter with offer of assistance, and a membership application was mailed to every chiropodist passing the Pennsylvania State Boards last July and November. A high percentage of the thirty-eight who took the Boards went into service but the remaining have become members. Indications are that the others will join us as soon as they have received their separation papers and established an office. It goes without saying that those taking the Pennsylvania Boards next July will be contacted by the committee.

Our immediate aim is for a five hundred one, full membership enrollment. The advantages are obvious in that it will mean another delegate to the National Convention, and considerably more strength

FOOT BALANCE INLAYS

are only completely
successful
when each case
is individually studied, diagnosed
and an inlay made to fit its
special requirements

The laboratory of

CARL G. BERGMANN, D.S.C.

5406 BROADWAY **CHICAGO 40, ILL.**

originator of foot balance inlays is directed
in all its endeavors to accomplish this result

when asking for improved legislation. This, coupled with our permanent goal of every member encouraging a student to make chiropody his career, should forecast a very bright future—membershipwise.

In closing this report the committee wishes to commend all of the Division Membership Chairmen for their cooperation during the past year and the fine job they have been doing in their home Divisions. Let us continue to solicit the nonmember and convince him that "Membership is a Privilege."

John C. Pankratz, D.S.C.
Ralph H. Orr, D.S.C., Co-chairman
Chiropody Society of Pennsylvania

APPOINTMENT

Dr. Andrew S. Anastasio of New Haven, Connecticut, has been appointed Chief Chiropody Consultant at the Woodruff Restorative Hospital, a state institution located in New Haven, Conn., designed to rehabilitate patients afflicted with chronic diseases and illnesses.

SCIENCE FAIR WINNER

Ann Shaw, daughter of Dr. and Mrs. L. B. Shaw, West Memphis, Arkansas, and Memphis, Tennessee, won first place in the district high school science fair at Jonesboro, Arkansas. Miss Shaw's exhibit was on "The Foot, The Organ of Locomotion." This is the second year in a row for Miss Shaw to win top honor.

COMMUNICATIONS FROM THE PROFESSION

To the Editor:

The following resolution was submitted to the membership of the Nebraska State Association of Chiropodists and was adopted by a vote of this entire membership by a margin of seventeen to three.

Resolution

WHEREAS the 1957 House of Delegates of the National Association of Chiropodists did, after extensive debate and considera-

LEAVES AN ANTISEPTIC FIELD FOR
TISSUE REDUCTION OR DEBRIDEMENT

WETTING 3 EMULSIFYING
WEA
ANTISEPTIC

CONCENTRATE

3-WEA is a very satisfactory means of softening heavy compact keratotic tissue, for removing the minor keratotic scale which appears on the feet of the geriatric patients, and for softening hyperkeratotic tissue around the nails.

USE IT EVERY DAY ON EVERY PATIENT

Ask your dealer for these two outstanding preparations:

Skin Adherent No. 2

and 3-WEA Concentrate

THE MOWBRAY COMPANY, Waverly, Iowa

tion, agree to become the American Podiatry Association and to use the terminology podiatrist-chiropodist and podiatry-chiropody in all literature, and

WHEREAS the term podiatry appears to be the term favored by medicine, the Armed Forces and the several government agencies, and

WHEREAS the Nebraska State Association of Chiropodists does favor the use of one and only one term to designate our profession

BE IT THEREFORE RESOLVED that the Nebraska State Association of Chiropodists does hereby go on record as being in support of the national organization and its officers and that it does further favor the terms "podiatry" and "podiatrist" and further desires that our national organization continue to be known as the "American Podiatry Association."

L. G. Lefler, D.S.C., Secretary
Nebraska State Association of Chiropodists

To the Editor:

In a recent "newsletter" to the profession, certain innuendos, charges and questions were posed regarding the action of the House of Delegates and Executive Council during the last year and during the 1957 annual meeting in Chicago.

As a delegate at that meeting I cannot let this go unchallenged. Many points alleged cannot stand closer scrutiny. First, the innuendo that all was not legal and a professional Parliamentarian was more or less forced on the House of Delegates is ridiculous. This gentleman helped conduct the meeting in an orderly, methodical manner and was invaluable to the president, Dr. Gamble. In fact, considering the issues involved, an excellent all-around job was done. As to the "tactics" employed in obtaining the reconsideration of the change of name from Chiropody to Podiatry, these were completely legal and according to Roberts Rules of Order which specify that a move to reconsider may be made in

OUR NEWEST MOULD

The Levy Latex Mould and Contour Inlay made completely of Latex and Sponge Rubber.

After many years of intense research and the cooperation of a prominent Doctor and Competitor, we have at long last succeeded in fulfilling the idea originated by Dr. Ben Levy TO CUSHION THE FOOT.

This product constructed of Sponge and Latex Rubber is far superior in comfort to any so-called space shoe, and, very important to our woman to-day, in no way mars the beauty of the shoe.

We strongly recommend it for those suffering from Arthritis, Circulatory or Diabetic conditions. Also for bony, rigid and sensitive feet as well as for Verruca, Ulcers and Scar Tissues. It also is made in an inlay type without crest.

The ORIGINAL CONTOUR is retained at all times.

A negative or positive Cast at right angle is necessary.

LEVY & RAPPEL, INC.
384 Columbus Ave., New York 24, N. Y.

the exact manner in which this was done.

That politics were played, can and will not be denied—but since when have politics not played a part in every national, or any other meeting. I was one of those who voted for Podiatry and represented the opinion of every one of my colleagues in the state of Montana and wish to state clearly and unequivocally that we believe Podiatry is the better designation for our profession and will so reaffirm next August in Washington.

If those responsible for this "newsletter" would have taken the trouble to look up the proceedings of the 1957 House of Delegates, they would have found a resolution was passed by the House of Delegates by an overwhelming majority, authorizing deficit spending. This was in order to carry over until the proposed raise in dues to the American Podiatry Association will take care of normal running expenses.

The publicity that accompanied the change-over was unfortunately not good in several cases. However, many more good press notices arose from the change. This again points out the need for additional national funds so we may have better public relations and this takes money—money not now available to our national.

If we continue to "hassle" over a name as we have for the past years ,and not use our energies for a better purpose, we, in a few decades, will not have to worry what we are called. We are dying faster than our colleges are graduating students.

The Executive Council has tried to show leadership and progressive thinking. It behooves all of us, delegates, state and regional officials, to back such leadership with a bit more time, patience and co-operation.

A. W. Friedl, D.S.C.
Great Falls, Mont.

To the Editor:

As one of the older men in our profession, I have seen many changes take place. For the most part we have progressed, and

VCR ACRYLIC 61956

. . . The new, self-curing, flexible resin. A "must" for every chiropodist's office. Simplicity itself for

- CRESTS
- SHIELDS
- NAIL GROOVE PACKING
- LOW VOLTAGE PHALANGEAL THERAPY
- MANY OTHER USES

Order from

VERNON - BENSHOFF CO.

P. O. Box 1587 Pittsburgh 30, Pa.

For Rigid Chiropody Appliances try
ORTHO-BOND • ORTHO-NET • ORTHO-FRE

in many areas our gains have been impressive.

In other phases of our work, we have not progressed as far as we would have liked to. There have been retarding influences and stumbling blocks, that have held us back.

One of the greatest of these stumbling blocks has been that of our dual terminology. We have been trying to march under two banners at the same time, that of Chiropody and that of Podiatry. We are all aware of this fact when we are asked by our patients, "Doctor, just what is the difference between a Chiropodist and a Podiatrist?" We should be disturbed at this question because we know that for every one who asks it, there are a thousand who are wondering and seeking the answer.

Because of this problem of carrying on our work under two names, I was delighted to hear that our National Association had at last faced, and apparently solved, this problem by changing the name of our national body to the American Podiatry Association.

I felt that at last we were going to be a unified profession. Just as we had every reason to feel that our one great stumbling block to progress had been removed, a group of men in our profession threw a bomb. These men tell us that they will not accept the term Podiatrist as the one name; they tell us they want to return to the two name handicap.

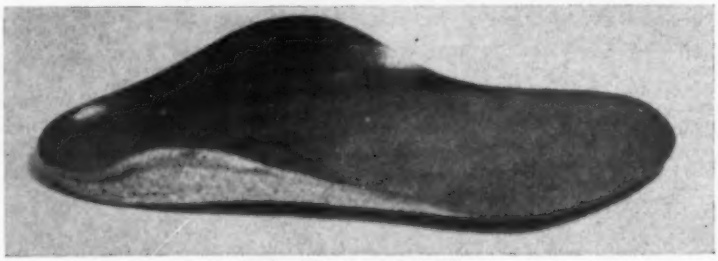
They would go further than this, by starting another organization; they would split our profession right down the middle; they would align us into two separate groups. In short, what these men propose is Civil War.

We all know what that means; in wars there are no winners—only losers.

A profession divided against itself cannot endure.

It is very possible—indeed probable—that if these men carry out their proposed course of action, they may well cause the complete

SAVE 2/3 of Your Laboratory Cost!



Style #2423 — Semiflexible

New, doubly reinforced, long length inlay, designed to cover the whole ball of the foot for easy forefoot balancing. Fully corked up and ready for balancing by grinding in your own office. Puts you in control with your better knowledge of your patients' needs. 53 sizes carried in stock for immediate shipment.

STYLE #423—Semiflexible—Molded leather shell. Same as #2423, but without cork on bottom.

STYLE #413—Flexible—Molded leather shell. Same as #423, but lightly reinforced.

Technique sheet, size run, and prices available upon request.

WRITE TODAY FOR YOUR BIG NEW VOSBURG CATALOG

Vosburg *Foot Appliance Company*

117 East 5th Street Austin 1, Texas

destruction of our profession. We must not let this happen.

Our course of action is clear. We must stand squarely behind our American Podiatry Association.

We must let these men who would divide us know that they can expect no help, no encouragement, no sympathy from us.

We must resolve to go forward under one banner—Podiatry.

We are Podiatrists—today, tomorrow and in the years to come—that way lies our true progress.

C. F. Whitney, D.S.C., Needham, Mass.

To the Editor:

The article, "An Improved Method for the Injection of Keramin in the Treatment of Heloma Neurofibrosum," in the March 1958 issue of the Journal of the American Podiatry Association, undoubtedly caught the interest of our fellow podiatrists. Dr. Vern Hall was generous with his attribution of credit to Dr. Marvin D. Steinberg as an acknowledged pioneer podiatrist in Keramin injection. However, it seems to me that the method therein described as "new" has some disadvantages.

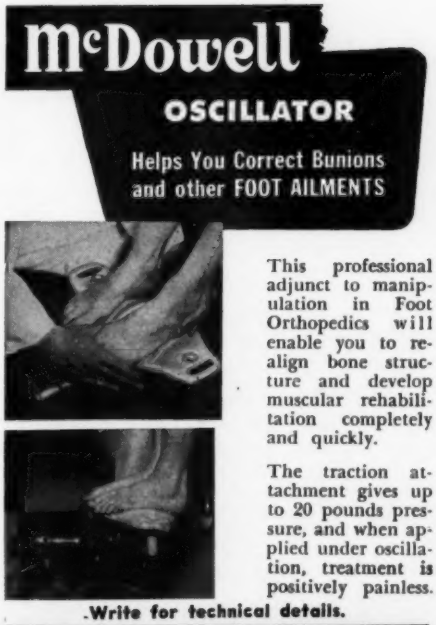
With all due respect to Dr. Vern Hall, whose article is well written, sincerely motivated, interestingly illustrated, the end purpose in the Hall technique is to inject without causing the patient needless pain. The technique of the posterior tibial block for plantar anesthesia was decribed many years ago by Dr. Marvin D. Steinberg. This method of anesthesia is a simple and completely painless procedure.

Dr. Steinberg has also conceived of the block as a therapeutic procedure and has taught this method of therapy for many conditions such as heel spurs, periostitis of the heel, gout, etc.

Once the plantar surface of the foot is anesthetized by the posterior tibial block, it is very simple to inject the Keramin solution.

Milton Gross, D.S.C., Passaic, New Jersey

COMFORTS
Cools, Relaxes
TIRED, BURNING, ITCHING FEET
ICE-MINT
MEDICATED FOOT CREAM
(contains lanolin)
When patients complain of tired burning feet as the heat soars, recommend soothing, cooling ICE-MINT. A white, clean, non-irritant cream containing the finest camphor gum, essential oils of peppermint, eucalyptus, thyme and camphor—in a special base containing soothing lanolin. Write for free samples.
UNITED SALES & MFG. CO.
Division of FOSTER-MILBURN CO.
468 Dewitt Street, Buffalo 13, N. Y.


McDowell
OSCILLATOR
Helps You Correct Bunions and other FOOT AILMENTS
This professional adjunct to manipulation in Foot Orthopedics will enable you to realign bone structure and develop muscular rehabilitation completely and quickly.
The traction attachment gives up to 20 pounds pressure, and when applied under oscillation, treatment is positively painless.
Write for technical details.
McDowell Manufacturing Co.
Pittsburgh 9, Pa.

BUTLER'S CHIROPODY SUPPLY CO.

Specialists in the Finest All Nationally Advertised Equipment

SURGERY TABLES	X-RAYS
AUTOCLAVES	CABINETS
STERILIZERS	CHAIRS AND STOOLS
ULTRASOUND	LAMPS
SINES & DIATHERMIES	DRILLS
WHIRLPOOLS	

INSTRUMENTS — **SUPPLIES**
CHIROPODY
SURGICAL

Arch Appliances made to specific prescription and cast work

Materials also stocked for making your own arch appliances.

5541 York Blvd., Los Angeles, Calif. CLinton 5-3049

1089 Market St., San Francisco 3, Calif. UNderhill 1-4551

BUTLER'S

"The House of Friendly Service"

TERMS TO SUIT

WRITE FOR PRICES AND DETAILS

To the Editor:

Dr. Murray Edelstein is to be commended on the article that appeared in the April 1958 issue of the A.P.A. Journal. The similarity between the plantar verruca and other childhood virus infections should receive more attention from our investigators and, to my knowledge, this is the first time anyone in our profession has made an effort to examine the pathomechanics of the verruca. I hope Dr. Edelstein will pursue this matter, because our profession should assume most of the responsibility for the common problems that we see in our offices, and it is up to us to provide a better understanding of them.

There are many clinical factors which suggest that the verruca should be classified among childhood diseases, and we concur with the observations reported by Dr. Edelstein. Besides the apparent immunity, these viruses have an affinity for the specialized cell structure on the plantar aspect of the foot. They have definite incubation periods and the incidence is greater in children. They are more difficult to treat when they do occur in adult life. Verruca have many of the characteristics of mumps, measles and the other childhood diseases. The only outstanding clinical difference is the fact that they do not appear to be communicable and the patients are seldom observed to be febrile during the infection.

Physicians often confuse the verruca with tyloma, and the same mistake is sometimes made by chiropodists. Most of the so-called re-occurrences are a result of improper diagnosis and inadequate therapy. I examine patients three weeks after all warts appear to have been eradicated so that we can be sure that there is no regrowth. I have not seen a second infection occur after the complete removal of a verruca. This would indicate that there is some form of immunity, because the patient continues to expose himself to the same elements.

Jack T. Sanders, D.S.C.
Albany, California

To the Editor:

I note on page 101 of the March issue of the Journal a quote by Frederick Lee Liebolt, M.D., excerpted from "Modern Medicine," as follows: "Too often shoe manufacturers influence not only the laity but also doctors with the advertisements of 'proper shoes.' In general, solid leather oxford shoes of the blucher type with the lace across the tongue are suitable for children. The soles should be thick and flexible. Bootees and soft sole shoes should never be worn."

The misfortune is that your own respected publication, as an authoritative voice on foot health matters, would publish this, thereby leaving the inference with your readers that there is medical substance to Dr. Liebolt's declaration. (**Editor's Note:** *We must agree with Dr. Rossi.*

Your Editor's this time not-so-eagle eye must have been looking the other way.)

Dr. Liebolt's definition of a "proper shoe" for children is so grossly open to challenge that I hereby offer $100 to him or anyone else who can provide acceptable scientific evidence before a qualified jury of experts that his specified type of shoe is more "proper" scientifically than, say, a soft-sole shoe.

This dogmatic, prejudiced attitude regarding footwear by medical practitioners continues, as in the past, to be one of the misfortunes in the area of foot treatment or foot health. While many doctors firmly advocate Dr. Liebolt's type of "proper" shoe, many others prescribe just the opposite types. How can both be so dogmatically right?

Medical lack of know-how concerning shoes is, of course, notorious. An example: "The soles should be thick and flexible," says Dr. Liebolt. This is a gross contradiction. The thicker a leather sole becomes, the more it loses flexibility. There is abundant scientific evidence (such as in the research laboratories of our own industry) to demonstrate that point. So the "thick, flexible" sole of leather is a naive illusion—but a dangerous one because it is propounded as a factual reality by a medical practitioner who is presumed to know what he is talking about.

Why is there such a dearth of information concerning footwear in the profession's journals? Why is a discussion of footwear (by qualified people) so consistently and conspicuously absent from the "scientific" programs and conventions within the profession? This, to observers such as myself, is a sheer evasion of professional responsibility.

I am sure that you and the entire podiatry profession would be amazed at the genuinely scientific work that is in process, regarding all phases of footwear, in the shoe industry. A tremendous amount of research is going on—and some of the information or findings or methods or equipment would astound the average podiatrist, whose normal reaction when confronted with this would be, "How long has *this* been going on?"

William A. Rossi, D.S.C.
Field Editor
Boot and Shoe Recorder

A PATIENT CAN BE ALL WET...
Yet keep a Doctored Foot DRY!
DRI-FOOT
The watertight latex sock that permits tub, shower, pool or surf bathing while an ailing foot is under treatment.
S-t-r-e-t-c-h-e-s on and off easily. Flesh pink. Sizes (as for shoes)
Small (2-5)
Medium (6-8)
Large (9-12)
Nubby, SKID-PROOF SAFETY SOLE
DRI-FOREFOOT
Frontal foot protection. Watertight at instep. One size fits all.
Write for detailed folder
DORSAY PRODUCTS
2 Columbus Circle, N. Y. 19, N. Y.

"I found him Mrs. Anderson!"

Postmaster General Accepts Foot Health Award

ON BEHALF of the American Foot Health Foundation and Podiatrists-Chiropodists of the Nation, President Hirschberg presented to the Postmaster General, the Annual Foot Health Award, as the representative of the 535,000 postal employees as they symbolize the importance of man's still one indispensable form of locomotion, the human foot.

In accepting the award, the Postmaster General said:

"Dr. Hirschberg, it is a real pleasure to accept this Annual Foot Health Award on behalf of the 535,000 employees of the Post Office Department.

"The efforts of the American Foot Health Foundation in directing the attention of the American people to the importance of foot health is a genuine public service.

"We in the Post Office Department are perhaps more appreciative of your efforts than many other organizations because the prompt and efficient delivery of the mails depends to such a large degree upon the work of human beings. These human beings to be fully efficient must be in the best physical condition and certainly any program such as yours, which contributes to this objective, is worthy of commendation."

Over thirty representatives of the various sections of the Post Office Department attended the ceremony.

CONVENTION DATES AND MEETING NOTICES

American Podiatry Association
Washington, D. C.
August 22-26, 1958
Shoreham Hotel

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Boston, Mass.
Oct. 17, 18, 19, 1958
Sheraton Plaza Hotel

Region Two
(New York)

Region Three
(Del., Md., N. J., Pa.)

Region Four
(Ohio)

Region Five
(Ill., Ind., Mich., Wis.)

Region Six
(Colo., Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Kansas City, Kans.
April 10-12, 1959
Town House Hotel

Region Seven
(Idaho, Mont., Oreg., Wash., Wyo.)

Region Eight
(D. C., N. C., S. C., Va., W. Va.)

North Carolina Chiropodists' Association
June 22-24, 1958
Wrightsville Beach, N. C.

Region Nine
(Florida)

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)
Memphis, Tenn.
Oct. 10-12, 1958
Peabody Hotel

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Dallas, Tex.
June 19-22, 1958
Statler Hilton Hotel

Region Twelve
(Ariz., Cal., Nev., Utah)

AMMENS.®
medicated
POWDER
for the feet

A SOOTHING BARRIER TO: • INFECTION • MOISTURE • IRRITATION

AMMENS is especially suitable for the feet because of its exceptional absorptive action. It spreads a cooling, soothing barrier to the effects of heat, moisture and to the hazard of subsequent bacterial invasion. AMMENS, unlike many other powders, is *medicated* to promote healing.

Bristol-Myers Company
19 West 50 Street, New York 20, N. Y.
Distributor for CHARLES AMMEN COMPANY • Alexandria, La.

A MEMBER OF THE PROFESSION YOUR PERSONAL CONSULTANT IN OFFICE PLANNING SERVICE

For ALL Your Office Supplies
Are You On Our Mailing List?
Should You Have An Office Economy Problem or Be Planning A New Office, Consult Sol Adler, D.S.C., Temple '37, Chiropody Economy Consultant.

SOL ADLER, DSC, ECONOMIC CONSULTANT . 25 YEARS OF DEDICATED SERVICE TO THE PROFESSION

ADLER
SURGICAL SUPPLY COMPANY
554 N. 17th St., Philadelphia 30, Pa., RI 6-0942

A WONDERFUL PLACE TO DO BUSINESS

GRISWOLD'S

FAMILY SALVE

Your insurance of a satisfied patient. The finest adhesive for felt.

Sold by all supply houses

The Griswold Salve Co.
Hartford, Conn.

MOOD ELEVATORS

Contributions to this column are more than welcome. In fact it depends upon them.
A.O.P.

"I can't cut my nails now," said the Older Lady Patient. "Once I could put my foot behind my neck but the last time I did it my husband said if I ever did it again he wouldn't undo me."

I scratched the front fender a little—if you want to look at it, it's in the back seat.

Homecoming wife reported in Successful Farming

Mrs. Blank was granted a divorce when she told the judge that since her marriage her husband has spoken to her only three times. She was awarded the custody of their three children.

News & Views

Presenting our new line of...

***Treatment Shoes**

At last a shoe that you can prescribe to a patient to be worn while the patient is undergoing treatment in your office.

- Simple plaster splint cast
- Has all the features of a molded shoe
- 10 day delivery
- Lightweight
- Beautifully styled

* Treatment shoes as outlined in a paper read before the ILLINOIS Chiropody Society.

Send for complete information.

NATURAL MOLD SHOE

318 E. Third Street
Mount Vernon, N. Y.

IT had been a good year and Daddy was feeling generous as Christmas approached. To his young son he asked, "What do you want most for Christmas?"

Promptly the youngster said, "A baby sister. I want her more than anything else."

Dad was stuck and showed it. The boy eyed him sharply; "Come on, Dad, that shouldn't be hard. You know what you always say when things get tough. Put more men on the job."

Perfectionist: One who takes infinite pains and often gives them to other people.

Kenneth L. Kirshbaum

I think we are going to France on our honeymoon because Charley said that just as soon as we were married he'd show me the place where he was wounded in the war.

Sweet young thing reported in the IMP

True Balance Inlays
and Full Extension Inlays

. . . made to your prescription.

Metal Whitman Braces

and all other metal braces made to casts.

For all special custom work, consult us.

Dr. Brachman Laboratories, Inc.
3126-30 N. HALSTEAD ST.
CHICAGO 14, ILL.

"I still don't think you had to bring all those plaster casts for your lecture tomorrow!!"

ADVERTISERS INDEX

	Page No.
Adler Surgical Supply Company	A37
Archcraft Laboratories	A14
Baltor Bracelet	A41
Rudolph Beaver Company	A26
Carl G. Bergmann, D.S.C.	A28
The Birtcher Corporation	3rd Cover
Dr. Brachman Laboratories, Inc.	A39
Bristol-Myers Company	A37
Butler's Chiropody Supply Company	A34
Chiropody Supply Headquarters, Inc.	A13
Cole's Orthopedic Laboratory	A41
Desitin Chemical Company	A3
Dome Chemicals, Inc.	A24, A25
Dorsay Products	A35
Foot Facts Publications	A42
Foot-So-Port Shoe Company	A1, A2
Goldberg, Dr. H. C.	A27
Gordon Laboratories	A41
The Griswold Salve Company	A38
Herbst Shoe Manufacturing Co.	A18, A19
Levy & Rappel, Inc.	A30
Liquid Rubber Appliance Laboratory	A40
Maltbie Laboratories Division	A9
McDowell Manufacturing Co.	A33
Mennen Company	A22
Merck, Sharp & Dohme	A17
The Mowbray Company	A29
Mutual Benefit Life Insurance Company	4th Cover
The NAC Agency, Inc.	A20
Natural Mold Shoe	A38
Orthopedic Frame Company	A5
Paragon Surgical	A11
Professional Printing Co., Inc.	A42
Publishers Authorized Bindery Service	A41
Roche Laboratories	A21
F. P. Stella & Sons Products	A27
United Sales & Mfg., Co.	A33
U. S. Vitamin Corporation	2nd Cover
Vernon-Benshoff Company	A31
Vosburg Foot Appliance Company	A32
Westwood Pharmaceuticals	A7
Winthrop Laboratories	A15
W. Wooley & Co.	A41

FOR THE FINEST IN LATEX SHIELDS

CUSTOM BUILT PROSTHETICS DESIGNED AND TAILORED
BY CHIROPODISTS FOR THE CHIROPODY PROFESSION
TO CASTS OR IMPRESSIONS

Hammer Toe

Bunion
and special types

Heloma Durum

LIQUID RUBBER APPLIANCE LABORATORY

NEW ADDRESS

45 Valley Way — Prompt Service

West Orange, N. J. — Send for brochure

FOR RESULTS TRY CLASSIFIED ADS

in the

JOURNAL

They will help secure a new location, practice equipment, apparatus, books, instruments, a successor, partner, associate or assistant. The Journal has proved an excellent medium for any of the above purposes. The classified columns can be of genuine service to advertisers and members. Commercial and personal rates are shown at the head of the column. If you desire more specific information concerning classified advertising, write to:

Journal of the American
Podiatry Association
3301 16th St., N. W.,
Washington 10, D. C.

LIQUID LATEX

Extra thick. You can thin it yourself to suit your needs. Granulated Cork — Leather Flour. Write for sample with prices.

W. WOOLEY & CO.
1016-CH Donald St., Peoria, Illinois

FOR SALE: Chair, stool, cabinet, drill and instruments. Write 604, c/o American Podiatry Association, 3301 Sixteenth Street, N. W., Washington 10, D. C.

COLE'S ORTHOPEDIC LABORATORY
FOR THE PROFESSION ONLY
KELLY L. COLE
CATALOGS SENT UPON REQUEST
12804 W. Washington Blvd.
Los Angeles 66, California

An Authorized Binding
for
JOURNAL
of the
American Podiatry Association

Arrangements have been made for subscribers to have their journals bound into distinctively designed books.

Twelve issues, January through December, bound in best grade black washable buckram, imprinted with your name on cover, cost but $4.15 per volume.

Bound journals serve as an immediate reference for research and information. Properly displayed, they create a psychological impact on the patient, implying the time and effort spent to keep up to date on the most modern techniques and treatment.

Ship journals parcel post. Within thirty days after receipt, bound volumes will be shipped prepaid anywhere in the U.S.A. Full remittance must accompany order.

PUBLISHERS' AUTHORIZED
BINDERY SERVICE
(Binders of all Journals)
5811 W. Division Street
Chicago 51, Illinois

TROUBLED TOES?

TRY THE BALTOR BRACELET

Patent No. 2471997 was granted to the Baltor Bracelet for DEVICES FOR STRAIGHTENING TOES. It will help to protect the integrity of the forefoot structure.

BALTOR BRACELET
3800 Poplar Ave., Brooklyn 24, N. Y.

FOR SALE: An established practice in a downtown location. Three treatment rooms fully equipped. Reasonable price and reasons for selling stated upon private inquiry. Kenneth J. Ott, D.S.C., 508 16th Street, Oakland, Calif.

The brand name for fine pharmaceuticals.
GORDON LABORATORIES

WARM WEATHER COMFORT FOR YOUR PATIENT

Aromatic Cooling Lotion
Provides rapid comfort for burning, aching, tired feet.

Mycomist
A fungicidal deodorant spray for shoes.

Packaged in 4 oz. plastic spray bottles. Available through all reliable dealers.

State and Parkview Roads **Upper Darby, Pa.**

CLASSIFIED ADVERTISERS

Advertisements not exceeding 30 words cost $3.00. Additional words 10 cents each.

Commercial classified advertisements—minimum 30 words $10.00; 30 cents per additional word.

All classified ads payable in advance. Remittance must accompany order for insertion.

Please do not ask for the names of classified advertisers in the JOURNAL who use box numbers. We accept such advertisements with the understanding that this information will not be released. Address replies or inquiries to the box number shown in the advertisement. They are promptly forwarded to the advertiser.

People with Foot Problems Like to Read About Their Condition. Try

FOOT FACTS

Publications

P. O. BOX 985
MIAMI BEACH 39, FLORIDA

CAPITAL or promoter wanted for marketing shoe with patented arch holder and bunion regulator. Many satisfied wearers are enthusiastic with this new improvement for foot health. Write 610, c/o American Podiatry Association, 3301 Sixteenth Street, N.W., Washington 10, D. C.

ATTEND
YOUR STATE, REGIONAL
AND
NATIONAL
MEETINGS

PRICED FOR QUICK SALE: PHILADELPHIA — Lucrative practice can be doubled by aggressive practitioner. This set-up must be seen to be appreciated. Newest Ritter chairs motorized (2), X-Ray Hydrotherapy, Electrotherapy, Fees $4 & $5. Money needed for manufacturing enterprise — $6,000 cash. NO TRIFLERS PLEASE. Write 606, c/o American Podiatry Association, 3301 Sixteenth Street, N. W,. Washington 10, D. C.

FOR SALE: WELL-ESTABLISHED practice in Philadelphia completely equipped and furnished. Hospital affiliation. Home may be purchased which has rented apartment for added income. Details given by letter. Write 602, c/o American Podiatry Association, 3301 Sixteenth Street, N. W., Washington 10, D. C.

FOR SALE: UNUSUAL OPPORTUNITY for a young man, established practice in wonderful location in South Florida. State full particulars in first mail, equipment included. Write 608, c/o American Podiatry Association, 3301 Sixteenth Street, N. W., Washington 10, D. C.

PRACTICE FOR SALE—Sixteen years same location, three air conditioned outside rooms plus reception. High fees, complete equipment, x-ray-polysines, Diathermy, Mycrotherm, Ultra Violet, etc. Priced low to right man and any reasonable terms required. Leaving city June fifteenth. Must sell. Dr. Lewis Davies, 7058 South Euclid Ave. at 71st Street, Chicago 49, Ill.

DON'T MISS
AN ISSUE

KEEP YOUR
DUES AND ADDRESS
CURRENT

always on hand...
easy to handle

spot-quartz LAMP

Intense
Germicidal
Ultraviolet

Especially valuable to the **PODIATRIST**

EASY — SAFE — CONVENIENT

An essential aid to every practice, the SPOT-QUARTZ Lamp is ideal for technics of contact radiation on local infected areas. Produces first degree erythema at contact in six seconds... at one inch in twelve seconds.

Hangs conveniently on the wall, complete in single 3-lb. unit. No additional transformers or equipment needed. As easy to use as a flashlight! With the Woods' filter, a valuable diagnostic tool.

30-DAY FREE TRIAL OFFER

Try the SPOT-QUARTZ Lamp in your own practice for 30 days. If you are satisfied it's invaluable to your practice, pay the invoice of $94.00 —otherwise, return the Lamp to us at no obligation. Use it as much as you like, don't worry about accidental damage; no charge whatever.

Free Booklet—"Compendium on Ultraviolet" plus medical journal reprints and descriptives

THE BIRTCHER CORPORATION
Los Angeles 32, California

THE BIRTCHER CORPORATION
Department NAC 658
4371 VALLEY BLVD., LOS ANGELES 32, CALIF.

☐ Send me the Birtcher SPOT-QUARTZ LAMP for a no obligation free 30-day trial
☐ Send Medical Journal Reprints and descriptives

Dr. _____

Address _____

City _____ Zone ____ State _____

HIS JOB: *To broaden your life and brighten your future—through science*

Mutual Benefit Life's Job:

TRUE SECURITY

FOR YOU AND YOUR FAMILY

Like the engineer and scientist, your profession too, shapes the future. Similarly, Mutual Benefit Life deals in the future—*your* future and your family's...offering you the finest, fullest protection in the life insurance field through the famed True Security.

True Security is just what the name implies—the ultimate in worry-free, trouble-free lifetime life insurance. As personal and precise as a prescription, it is created for you and you alone—matched to *your* particular earning curve, *your* present needs, *your* future objectives.

Your Mutual Benefit Life man, like a scientist, conquers the unknown by means of the known. Using current facts about your job, your family, he considers every provision you'll need in the future in the plan he creates for you today. Only such a plan—based on today, built for tomorrow—can offer you True Security.

Whatever your income today, *now* is the time to investigate True Security. It is now offered with the most liberal coverage in Mutual Benefit Life's 113-year history, and at a new, low cost.

MUTUAL BENEFIT LIFE

The Insurance Company for TRUE SECURITY

THE MUTUAL BENEFIT LIFE INSURANCE COMPANY, NEWARK, NEW JERSEY